Disability in Scotland
A Baseline Study

Sheila Riddell and Pauline Banks

A report prepared for the Disability Rights Commission Scotland Office by the Strathclyde Centre for Disability Research, University of Glasgow, June 2001
The Disability Rights Commission (DRC) is an independent body, established by Act of Parliament to eliminate the discrimination faced by disabled people and promote equality of opportunity. When disabled people participate - as citizens, customers and employees - everyone benefits. So we have set ourselves the goal of “a society where all disabled people can participate fully as equal citizens”.

We work with disabled people and their organisations, the business community, Government and public sector agencies to achieve practical solutions that are effective for employers, service providers and disabled people alike.

There are roughly 8.5 million disabled people in Britain - one in seven of the population. This covers people with epilepsy, cancer, schizophrenia, Down’s syndrome and many other types of impairment.

Under the Disability Discrimination Act (1995), many legal rights and obligations affecting disabled people’s access to services and employment are already in force. Others become law in 2004.

Many people are still not aware that they have many new rights. And employers and service providers are often unsure how to implement “best practice” to make it easier for disabled people to use their services or gain employment.

The DRC has offices in England, Scotland and Wales. We are here to assist and advise through our Helpline, Disability Conciliation Service, the Casework, Legal, and Practice Development Teams, publications, research and policy work.
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Acknowledgements

Sheila Riddell and Pauline Banks would like to acknowledge the advice and help given by the following people in producing this baseline study:


In particular, we would like to thank Jean McPartland for producing the manuscript and, as ever, remaining calm as deadlines approached.
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<td>AHT</td>
<td>Acute Hospital Trust</td>
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<td>CMR</td>
<td>Continuous Morbidity Recording</td>
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<td>CoSLA</td>
<td>Convention of Scottish Local Authorities</td>
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<td>DDA</td>
<td>Disability Discrimination Act</td>
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<td>DEA</td>
<td>Disability Employment Adviser</td>
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<td>DETR</td>
<td>Department of Environment, Transport and the Regions</td>
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<td>DfE</td>
<td>Department for Education</td>
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<td>DfEE</td>
<td>Department for Education and Employment</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DPTAC</td>
<td>Disabled Person’s Transport Advisory Committee</td>
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<td>DRC</td>
<td>Disability Rights Commission</td>
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<td>DRTF</td>
<td>Disability Rights Task Force</td>
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<td>DSA</td>
<td>Disabled Student’s Allowance</td>
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<td>DSS</td>
<td>Department of Social Security</td>
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<td>EA</td>
<td>Education Authority</td>
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<td>ES</td>
<td>Employment Service</td>
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<td>GB</td>
<td>Great Britain</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HEI</td>
<td>Higher Education Institution</td>
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<td>HESA</td>
<td>Higher Education Statistics Agency</td>
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<td>HIA</td>
<td>Health Impact Assessment</td>
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<td>HIP</td>
<td>Health Improvement Programme</td>
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<td>IB</td>
<td>Incapacity Benefit</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>ISD</td>
<td>Information and Statistics Division</td>
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<td>LEA</td>
<td>Local Education Authority</td>
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<td>LEC</td>
<td>Local Enterprise Company</td>
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<td>NASiS</td>
<td>National Health Service in Scotland</td>
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<td>NDDP</td>
<td>New Deal for Disabled People</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>PA</td>
<td>Personal Adviser</td>
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<td>PAYE</td>
<td>Pay as You Earn</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>RSAMD</td>
<td>Royal Scottish Academy of Music and Drama</td>
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<td>RTP</td>
<td>Residential Training Provider</td>
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<td>SEHD</td>
<td>Scottish Executive Health Department</td>
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SEN Special Educational Needs
SHAS Scottish Health Advisory Service
SMR Standardised Mortality Ration
SOIED Scottish Office Education and Industry Department
SWSI Social Work Services Inspectorate
UK United Kingdom
Foreword

This research report was commissioned by the Disability Rights Commission (DRC) Scotland Office as a major step towards highlighting the needs and rights of disabled people in Scotland. This work builds on much of the progress that has been made on raising awareness of disability issues, particularly since the Disability Discrimination Act (DDA) was passed. With the establishment of the DRC we now have a new force to raise the debate on matters of concern for disabled people.

The DRC exists to eliminate discrimination against disabled people and promote equality of opportunity. One of the functions of the DRC is to carry out research to inform discussion and policy-making and this report is aimed at contributing to knowledge in this area. Until now there has been no comprehensive overview of the picture of disability in Scotland and it was essential that this gap was filled.

Our aim is that this research should be of value to all concerned with disability issues including disabled people; the Scottish Executive; academics and researchers; research funders; policymakers at local, regional, Scotland and UK level; MSPs and MPs.

There are a number of people I would like to thank, in particular Sheila Riddell and Pauline Banks for their hard work in compiling this report with a very tight deadline. I’d also like to thank Sally Witcher for her work managing the project and members of the advisory group - Jim Elder-Woodward, Andrew Reid, Sue Warner and Margaret Whoriskey.

As I said earlier we want to raise the debate but more importantly we wish to use these findings to help all those concerned with disability rights to formulate future agendas for action in Scotland.

Bob Benson
Director, Scotland
Disability Rights Commission
Introduction

This baseline study aims to provide an overview of policy, official statistics and research in relation to disabled people in Scotland. The timing of this review is important because it coincides with a number of major policy developments in Scotland and in the wider GB and UK context. The Disability Rights Commission (DRC), established in 2000, is having a growing influence on government thinking. The rights of disabled people throughout GB are being increased through the extension and review of the Disability Discrimination Act 1995 (DDA). Finally, the Scottish Parliament is having a major impact on the lives of people in Scotland, forging new welfare agendas. A desire to achieve a more inclusive society is at the heart, rather than the periphery, of government concerns. In order to ensure that the interests of disabled people in Scotland are reflected in policy, there is a need for much better information about their experiences and needs. Until very recently, disabled people tended to be somewhat marginalised and invisible, with factors such as socio-economic status and gender attracting far more research interest. Due to pressure from the disability movement, this situation is now changing and there is growing recognition of disabled people as a distinctive group engaged in a struggle against specific forms of oppression. Knowledge is a powerful instrument in the struggle for social justice, and this baseline study seeks to provide a broad brush picture of what is currently known about disabled people in Scotland and where new information is required. It sketches some features of a future research agenda to be considered by the Disability Rights Commission, the Scottish Executive and other organisations with an interest in commissioning research to advance social justice in Scotland such as the Joseph Rowntree Foundation. Given the short timescale of the study, which was conducted over a two month period between February and March 2001, the review of policy, official statistics and research could not be exhaustive. However, we hope that it provides an overview of existing knowledge about disabled people in Scotland, the linkages between different areas of social policy and between the Westminster and Holyrood Parliaments.

Disability in Scotland: The Policy Framework

The connection between disability and disadvantage has been well documented in the UK context by writers such as Barnes (1991). However, there has been less focus on disability in Scotland, despite the fact that
Scotland differs politically, geographically, economically and socially from the rest of the UK. The Scottish Parliament has responsibility for equal opportunities, and has agreed:
To promote opportunity for all and to do that through an inclusive phased and participative approach to the development of an equality strategy so ensuring that in developing policy and in service design and delivery concern for equality is at the heart of the matter. (Scottish Executive, 2000a: 3)

In order to promote equality of opportunity, there is clearly a need for the gathering and analysis of data charting patterns of inequality. The Scottish Executive has begun to collate disability statistics (Scottish Executive, 2000b), which reveal the wide extent of the economic and social exclusion experienced by disabled people.

A number of developments in the Scottish and wider GB context, make this baseline assessment particularly timely. These include the following:

(1) **The implementation of the Disability Discrimination Act 1995** makes it essential to establish some benchmarks in relation to the discrimination and disadvantage experienced by disabled people in Scotland so that future change can be monitored. The DDA is GB wide legislation and makes discrimination on grounds of disability unlawful. Discrimination is defined as less favourable treatment delivered to a disabled person from that which a non-disabled person might expect to receive. Provisions of the Act relating to employment and goods and services have already been implemented and the Act has now been extended to school, further and higher education through the SEN and Disability Act, 2001. Current evidence on the implementation of the DDA, summarised by Gooding (2000), suggests change has been slow. To ensure that the pace of change speeds up, ongoing monitoring is essential using Scottish data, which may then be compared with the GB picture.

(2) **The Disability Rights Task Force (DRTF)** was set up in December 1997 with the following terms of reference:

To consider how best to secure comprehensive and enforceable civil rights for disabled people within the context of our wider society, and to make recommendations on the role and functions of a Disability Rights Commission. To provide the latter by March 1998 and to provide a full report of its recommendations on wider issues no later than July 1999.
The report (DfEE, 1999a) discussed and made recommendations in relation to the following areas: education; employment; access to goods, services and premises; travel; the environment and housing; participation in public life; local government; health and social services. Responses to the DRTF report were made by both Westminster (DfEE, 2001) and Holyrood (Scottish Executive, 2001a). This study gathers information in relation to most of the areas addressed by the DRTF report, with the aim of identifying key indicators of progress in relation to disability rights.

(3) The establishment of the Disability Rights Commission (DRC) in April 2000, with offices in Manchester, London, Edinburgh and Cardiff, further underlines the seriousness with which the Government is pursuing its equality agenda. The goal of the DRC is to achieve ‘a society where all disabled people can participate fully as equal citizens’. The statutory duties of the DRC are the following:
1. to work to eliminate discrimination against disabled people
2. to promote equal opportunities for disabled people
3. to encourage good practice in the treatment of disabled people
4. to advise the government on the working of disability legislation

An over-arching aspect of the DRC’s mission is to monitor the DDA and make recommendations on adjustments and amendments to the existing legislation. Establishing baseline measures concerning the position of disabled people in Scotland will clearly underpin all these activities. Since key aspects of Scottish legislation, policy and provision differ from those in England and Wales, it will be vital for the DRC to have access to reliable Scottish data.

(4) The establishment of the Scottish Parliament under the terms of the Scotland Act 1998 underlined the importance of disaggregating data gathered from different parts of the GB in order to chart the growing policy divergence which is emerging (Salisbury and Riddell, 2000). Table 1.1 illustrates the division between devolved and reserved matters.

Under the terms of the Scotland Act 1998, responsibility for equal opportunities is reserved to Westminster, although responsibility for the implementation of equal opportunities policies is devolved to the Scottish Parliament. In practice, there are often overlaps between
reserved and devolved matters. For example, Part IV of the DDA relating to education establishes common anti-discrimination principles which apply throughout GB. However, they are implemented within the separate schools educational frameworks for Scotland and England and Wales. Similarly, social security and employment policies are reserved matters, but are closely-connected with economic development, education and training which are devolved matters. There are currently a number of political sensitivities around the devolution settlement with Westminster and Edinburgh politicians and civil servants anxious not to tread on each other’s toes. However, as devolution beds down there will undoubtedly be some further negotiation over government boundaries.

In the Scotland Act, equal opportunities is defined as:

The prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions.

\[\text{Table 1.1: Responsibilities of the UK and Scottish Parliaments}\]

<table>
<thead>
<tr>
<th>Devolved matters</th>
<th>Reserved matters</th>
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<tbody>
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<td>Health</td>
<td>The constitution of the United Kingdom</td>
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<tr>
<td>Education</td>
<td>UK foreign policy</td>
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<tr>
<td>Training</td>
<td>UK defence and national security</td>
</tr>
<tr>
<td>Local government</td>
<td>UK fiscal, economic and monetary system</td>
</tr>
<tr>
<td>Many aspects of transport</td>
<td>Common markets for UK goods and services</td>
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<tr>
<td>Social Work</td>
<td>Employment law</td>
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<tr>
<td>Housing</td>
<td>Social security</td>
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<td>Economic development</td>
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<td>The legal system and law &amp; order</td>
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<td>The environment</td>
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<td>Agriculture, fisheries and forestry</td>
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<td>Sport</td>
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<td>The arts</td>
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\textbf{Source: Scottish Executive, 2000a.}
Given the slightly uneasy split between reserved and devolved equality issues, it is vital for there to be easily available and reliable information on the position of disabled people in Scotland. If such data are not available, there is a danger that equality policy may tend to reflect the English rather than the Scottish context.

(5) The implementation of the Human Rights Act 1998 has specific implications for disabled people and widens the extent to which a disabled individual will be able to seek legal redress (Daw, 2000). In addition, European legislation may accord more rights to disabled people. Data from the baseline study will be useful to the DRC in assisting disabled people to make use of these opportunities to access justice.

(6) The Scottish Executive’s social inclusion agenda has clear implications for disabled people. Since Townsend (1979) published his extensive analysis of the nature and causes of poverty in the UK, it has been recognised that poor people are much more likely to be disabled than others, and disabled people are much more likely to be poor. In other words, disability is both a cause and an effect of poverty. More recent studies have reaffirmed this association between disability, poverty and exclusion (e.g. Burchardt, 2000).

In April 1999 the government established the Social Inclusion Partnership programme to tackle social exclusion in some of Scotland’s most deprived areas. Factors contributing to social exclusion were identified as poor health, exclusion from education, long-term unemployment, inadequate housing, lack of childcare, crime and fear of crime, and poor transport. Forty-eight Partnerships have been established, some of which are locality based and others thematic. The aim of the programme is to tackle both existing exclusion, but also prevent it occurring in the future by addressing multiple problems using a multi-agency approach.

The Scottish Executive launched its social inclusion strategy in 1999 with the publication of the document Social Justice...a Scotland where everyone matters (Scottish Executive, 1999a). The Scottish Executive committed itself to the following goals:
- the elimination of child poverty
- full employment by providing opportunities for all those who can work
- securing dignity in old age
- building strong, inclusive communities.
Twenty-nine milestones were identified against which progress would be reported annually. The only one of these milestones to refer explicitly to disabled people was milestone 17:

- increasing the proportion of people with learning disabilities able to live at home or in a ‘homely’ environment.

Some milestones deal with factors creating disability such as coronary heart disease and alcohol misuse. However groups referred to as requiring specific support do not include disabled people. (see, for example, milestone 15 which identifies the goal of increasing the employment rates of disadvantaged groups, such as lone parents and ethnic minorities, that are relatively disadvantaged in the labour market).

The first Annual Report reviewing the milestones was published in November 2000 (Scottish Executive, 2000c). The final section Measuring Progress draws attention to the paucity of data on which to base anti-poverty strategies. A commitment to tackle the most significant gaps focussed on upgrading the data available from the Scottish Household Survey, income data, small area data, and data relating to equality issues, and rural poverty.

Whilst the social justice agenda holds out promise that the Scottish Executive intends to redress existing injustices, there is a danger that disabled people may not be recognised as a group with particular interests. It should be noted, however, that disabled people are recognised in the Scottish Executive’s Equality Strategy (Scottish Executive, 2000a) and that, linked with the modernising government initiative, the Scottish Executive is committed to the production of better statistics on disability. The Convention of Scottish Local Authorities (CoSLA, 1999) has also made clear that equality of opportunity for disabled people must be considered as an integral part of best value in service provision. There are optimistic signs that the Scottish Executive intends to improve its monitoring of the position of disabled people and this study provides some ideas on key indicators for future analysis.

**RESEARCH AIMS**

In line with the research specification produced by the Disability Rights Commission, this study:

- Provides an overview of the broad Scottish legislative and policy context in which the experiences of disabled people are located. This includes
an analysis of the political, economic, social, legal and cultural environment which have shaped the experiences of disabled people and given rise to a particular approach to equality issues.

- Presents available data on developments/trends in particular policy areas. These include employment, access to goods and services, housing, health and social care, education and transport. As well as collating data from a range of sources, gaps in available information, statistics and datasets are identified.
- Identifies the implications of the extension of disability rights in terms of the capacity of the existing infrastructure to respond.

Recommendations are made in relation to each of these areas. The prime concern is to identify areas where further information is required, the form in which such information might be made available and the wider social, policy and statutory changes which may be needed to ensure that equality for disabled people is achieved.

DEFINITIONS OF DISABILITY AND OFFICIAL STATISTICS

As part of its Equality Strategy, the Scottish Executive is committed to gathering better information on patterns of inequality to inform the work of disability activists, researchers and policy makers. In line with this overall aim, the Scottish Executive has published a document entitled *Equality in Scotland: Guide to Data Sources* (Scottish Executive, 2000b). It is clear that a number of surveys and Government departments are already gathering information on the position of disabled people in Scotland, but a closer look at the data indicates that much information is based on different definitions of disability and therefore it is difficult to compare findings from different sources. This is partly because information has in the past been gathered in a somewhat unco-ordinated manner, but, in addition, it is to do with inherent complexities in understandings of disability. Here, we describe briefly the different ways in which disability is understood by a range of Government agencies and large-scale surveys. Subsequently, definitions employed by disability theorists are explored, which tend to be at variance with those used within official statistics. The complexity of definitions is illustrated with reference to education, where a number of definitions of disability are used resulting in different populations being identified as disabled by different agencies and at different educational stages. Finally, we consider the political argument for the gathering of statistics relating to disability, which suggests that whilst no definition will please all, some common definition is essential to inform the process of political change.
Competing definitions of disability
The Disability Discrimination Act 1995 defines disability as ‘a physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities’. People who have a disability, and people who have had a disability but no longer have one, are covered by the Act. To claim protection under the DDA, a claimant must first establish that s/he is disabled, or has been in the past, under the terms of the Act. This contrasts with the Sex Discrimination Act 1975 and the Race Relations Act 1976 which prohibit discrimination against anyone on grounds of gender or race. One of the major problems arising from the legislation thus far has been establishing that the claimant is indeed disabled under the terms of the Act. Whilst the Act does not elaborate on the nature of physical impairments, Schedule 1 states that mental impairment includes learning difficulties and impairments resulting from or consisting of a mental illness, but only if this is clinically well recognised. An impairment’s effects on normal day to day activities must be substantial, but if a person with a progressive condition, e.g. multiple sclerosis begins to experience symptoms of the condition, however slight, they are covered by the Act. This will continue to be the case if the symptoms go into remission. Schedule 1 contains the following prescribed and finite list of day to day activities: mobility; manual dexterity; physical co-ordination; continence; ability to lift, carry or move everyday objects; speech; hearing; sight; memory; the ability to learn, understand or concentrate; the perception of risk or danger. The definition does not cover a person who cannot carry out a specialised task required for their work unless it also has an impact on some more generalised activity.

Gooding (2000) notes that if a case is brought under Part II of the Act, it has become commonplace for employers to challenge whether an applicant meets the DDA’s test of a disability. Meager et al (1999) analysed all employment cases heard in the first 18 months of the Act and found that 18% of cases heard at tribunals failed on the definition of disability. It has been particularly difficult to establish that a person experiencing problems relating to heart, blood pressure or circulation and anxiety/depression is covered by the DDA and about half of DDA cases fail on definition issues.

Clearly, the DDA definition is based on a notion of ‘normal functioning’ and places the onus on the individual to demonstrate that their individual impairments prevent them from undertaking normal day to day activities. This emphasis on the individual rather than his/her physical, social or cultural environment might be described as a ‘medical model’ approach
and has been criticised by disability activists and theorists. A normative approach is also evident in definitions employed in large scale surveys such as the Labour Force Survey, which poses the question:

Do you have any health problems or disabilities that you expect will last for more than a year?

In addition, there is an elision between health problems and disability, although of course a disabled person may be perfectly healthy. Statistics which amalgamate very different groups of people (e.g. a person of 85 who has Alzheimer’s Disease with a young person who is a wheelchair user following an accident) may have limited use in terms of informing policy and practice and indicating service needs.

Whilst different criteria are used to establish entitlement to different social security benefits, ideas about normal functioning also underpin definitions of disability used in this area. The state has an interest in defining fairly tightly what counts as a disability so that access to such benefits are restricted to a limited section of the population. In order to qualify for certain benefits, such as Incapacity Benefit or Income Support with Severe Disablement Allowance, an individual is required to undertake the All Work Test. A medical practitioner must certify that the person is permanently incapable of employment and classifies their impairment within a medical categorisation system. However, there are political pressures for change in this area. The Green Paper *New Ambitions for Our Country: A New Contract for Welfare* (DSS, 1998) expressed reservations about the wisdom of establishing firm and impermeable boundaries between those deemed able and unable to work, and suggested the use of an additional assessment to identify the tasks a person might be able to perform following reasonable adjustments to the working environment. Personal Capability Assessments, running in tandem with the All Work Test, have been piloted in certain areas of the country.

Definitions considered thus far have tried to distinguish the disabled population from the non-disabled population by requiring the former group to demonstrate deficiency in normal daily functioning. A somewhat different definition is used in school education, which adopts the language of needs rather than deficiencies. Under the terms of the Education (Scotland) Act 1980 (as amended), children are identified as having special educational needs if they have much greater difficulty in learning than most other children of their own age or suffer from a disability which prevents them being educated with their own age group. Whilst this definition is still
normative, it is not based on the categorisation of impairment and allows for the recognition that a child’s learning environment will affect their educational progress. Two per cent of school pupils are recorded as having special educational needs, including the majority, but not all, disabled children. The social work definition of children in need also goes beyond those who are recorded (see Chapter 2 for further discussion).

In higher education, disability is defined differently. Students self-classify into a number of medical categories of disability and 5% of university students define themselves as disabled. Some disabled HE students might not be covered by the DDA, if their impairments were deemed insufficiently significant to affect normal day to day activities. The use of the DDA definition of disability under the terms of the SEN and Disability Act 2001 introduces another layer of complexity into establishing reliable estimates of the number of disabled school pupils and students.

**ALTERNATIVE DEFINITIONS OF DISABILITY**

Disability theorists and activists have developed different ways of understanding disability which fundamentally challenge the official definitions discussed above. Mike Oliver, in his groundbreaking book *The Politics of Disablement* (Oliver, 1990), argued that disability should not be seen in terms of individual deficits but rather as a reflection of the social, cultural and political factors which systematically exclude people with impairments. The focus thus shifted dramatically from an individual to a social deficit view, illustrated by the picture on the book’s cover which depicts a wheelchair user in front of a polling station accessed via a flight of steps. Social modellists acknowledge the existence of impairment, but note that an impairment is only disabling if society makes it so. Within the disability movement, debates continue about the meaning of the concepts of impairment and disability. However, the basic message remains that if barriers are removed then impairments will be much less disabling. Clearly, the social model in its pure form is at variance with the types of definitions used in the Disability Discrimination Act, in official surveys and in social security regulations. Another theory of disability, normalisation, also emphasises the social construction of disability. Often applied to people with learning disabilities and mental health problems, the theory of normalisation, developed by writers like O'Brien (1987), suggests that if disabled people occupy normal social roles they will be afforded recognition and equality. This theory emphasises the social stigma experienced by disabled people and has less to say about the economic structuring of oppression which underpins the
social model. At one level, however, the messages of the social model and normalisation are the same: it is a waste of time to count medically defined impairments. What matters is to remove social barriers to inclusion.

A social model understanding of disability might be reflected in the following question:

As a result of a physical or mental impairment, have you been stopped from doing anything, or going anywhere, or achieving any goal, by:
1) The attitude of any person or group
2) The design or operation of any thing or object
3) The rules or procedures of any organisation or body
4) The structure or process of any organisational system?

Clearly, there is a need for further thought and discussion about how disability should be defined operationally. For the rest of this report, we use the definitions and terminology adopted by particular agencies, whilst recognising their shortcomings.

ESTIMATES OF THE NUMBER OF DISABLED PEOPLE IN SCOTLAND

As the above discussion makes clear, there are no absolutely reliable estimates of the number of disabled people in Scotland. The only primary data which are available are drawn from the OPCS study (Martin et al, 1988), which estimated that there were 612,000 disabled adults in Scotland and 33,800 children (Bone and Meltzer, 1989). Since these surveys were undertaken, there are likely to have been increases in the number of disabled people in Scotland due to the fact that the population is ageing and older people are more likely to experience impairment. Henderson and Henderson (1999) report that in 1996 there were likely to be 640,000 disabled adults in Scotland, an increase of 30,000 on the OPCS figures. The Scottish Executive Health Department (1999), based on its own data, estimated that in 1999 there were 800,000 disabled adults in Scotland.

Estimates of the number of particular sub-groups of disabled people based on age and nature of impairment may be extracted from survey data. In 1996 in Scotland, 1.7% of the population was estimated as being visually impaired, although only 0.6% of the population are registered as visually impaired (Royal National Institute for the Blind estimates, 1997). 18% of people in Scotland are estimated to have some degree of hearing loss (National Study of Hearing, 1995). 4% of the population is estimated to have learning disabilities (Espie et al, 1999).
In 1999 in Scotland, 779,000 people of working age (25% of working age population) had health problems they expected would last for more than one year (Labour Force Survey, 1999). 504,000 people of working age (16.3% of working age population) had a long term disability which affected the type of work they could do. 484,000 people of working age (15.6% of working age population) had a long-term disability substantially affecting their day-to-day activities (the DDA definition of disability). The proportion of disabled people increases with age (see Figure 1.1).

**Figure 1.1: Disabled people in particular age groups expressed as percentage**

![Bar chart showing the percentage of disabled people in various age groups](chart.png)

*Source: Martin et al 1998*

At an early age, boys are more susceptible than girls to impairments caused by ‘germs, genes and trauma’. This is reflected in education statistics, where two thirds of pupils with Records of Needs are male. Among the working age population, there are slightly more disabled men than women. Women make up 59% of the overall population of disabled people because they have a longer life expectancy than men and older people are more likely to become disabled. However, among the adult population the pattern is more complicated (see Figure 1.2). In the 16-19 year old age group, men outnumber women, reflecting the childhood pattern, however, within the age range 25-39, women slightly outnumber men. In the age group 40-44, there are more men than women; this is the age at which men are particularly likely to become incapacitated as the result of work-related injury. From age 55 onwards, women outnumber men due to greater longevity and associated disabiling conditions.
Sex differences in the population of disabled people are therefore due to a complicated mix of biological, social and cultural factors.

CONCLUSION

In this introductory section we outlined the need for a baseline study of disability in Scotland. Whilst the DDA seeks to ensure equity of provision for disabled people throughout GB, the context of devolution means that equality policies are being implemented in different social, cultural and political contexts. In some areas (e.g. employment, benefits) common policies apply across GB. In other areas, such as health, education and housing, the DDA is being implemented in completely different policy frameworks. At local level, policies are likely to differ not only in different parts of GB but also within Scotland.
In the introduction, we have also discussed the significance of the competing definitions of disability which are used as the basis for collecting official statistics, within national surveys and by different public agencies. Definitions are contested because, unlike sex, disability is not genetically determined but is always identified and experienced within a particular social, political and economic context. Conflicts over definitions are clearly evident within the context of the DDA, where many cases which reach tribunal fail on the grounds that the person is deemed not to qualify as disabled under the terms of the Act. Looser definitions, such as are employed in education, are also problematic because they produce variables patterns of identification and of service provision across the country. The social model suggests an alternative way of understanding disability. However, this has not been translated into a widely accepted operational definition. The Scottish Executive is encouraging the use of harmonised definitions of disability across different surveys to allow for a greater degree of comparability between datasets. The following harmonised questions are recommended by the Scottish Executive:

*Do you have any long-standing illness, disability or infirmity?*

*By long-standing it is meant anything that has troubled you over a period of time or that is likely to affect you over a period of time?*

*(If answer = “yes”), Does this illness or disability limit your activities in any way?*

Clearly, these questions are contentious in that, like the Labour Force Survey, they conflate illness and disability. It is evident that in the future, further discussion of definitional issues will be needed.
INTRODUCTION

In the following review of policy, official statistics and research on educational provision for disabled children and adults in Scotland, we outline the key policies which have shaped educational provision and consider how these are evolving. Subsequently, we consider the nature of the official statistics which are available and the messages which may be drawn from them. We also identify gaps in statistical information which might be addressed in the future. We then provide a brief overview of current educational research in relation to disabled children and adults, again identifying gaps in knowledge which future research might address. Finally, we consider possible future policy developments in relation to disabled children and adults in Scotland. A great deal of emphasis is currently placed on ‘joined-up policy’. We therefore consider overlaps in education, social work and health policies and the implications of closer rapprochement between these agencies in the future.

CURRENT POLICY

Educational services are not simply concerned with provision for disabled children, but increasingly with lifelong learning. However, policy frameworks and patterns of provision for compulsory or post-compulsory stages of education are very different and are therefore considered separately.

The school policy framework
The Warnock report (DES, 1978) has been seen as a watershed in thinking about provision for disabled children. Before 1978, children were ‘ascertained’ by medical officers as in need of ‘special educational treatment’ if they were deemed to fit into one of the following nine legal categories of ‘handicap’: deafness, partial deafness, blindness, partial sightedness, mental handicap, epilepsy, speech defects, maladjustment and physical handicap. The categories did not include children with milder learning difficulties, nor those whose difficulties stemmed from such factors as absenteeism or frequent change of school. (See Scottish Consumer Council, 1989, for review of the legal background). Children with significant learning difficulties might be labelled as ‘uneducable and untrainable’ and were the responsibility of health rather than education. An Act of 1974 stated that all children were capable of being educated and responsibility for those previously seen as ‘uneducable and untrainable’ shifted from health to education.
There was growing dissatisfaction with the medical view of a fixed ‘disability of mind and body’ and the Warnock report suggested a new and all-embracing category of ‘special educational needs’ to replace the former statutory categories. Whilst recognising that about 20% of children experienced learning difficulties at some time during their education, Warnock suggested that the 2% of children with the most significant difficulties should be assessed by a multi-disciplinary team and their special educational needs recorded formally, along with a legally binding statement by the authority of how it intended to meet these needs. These recommendations were incorporated into the Education (Scotland) Act 1980. The formal document was called the Record of Needs in Scotland and its English equivalent was termed the Statement of Needs.

Inclusive education

Whilst recognising the on-going need for some specialist schools and units, Warnock recommended that most children with special educational needs be included in mainstream schools. Inclusive education was a major theme of the Advisory Committee on the Education of Children with Severe Low Incidence Disabilities (the Riddell Report) (Scottish Executive, 1999b) and the Parliament Committee Report on Inquiry into Special Educational Needs (Scottish Parliament, 2001). However, there is considerable uncertainty about exactly what is meant by inclusive education and what might be regarded as appropriate indicators of progress. Some groups in Scotland, such as the Equity Group, wish to see the closure of all segregated provision. Official policy, however, regards special schools and units as having an ongoing role in providing specialist education for a small group of children. The Scottish Executive does not see some segregated provision as incompatible with the wider goal of inclusion, although it does wish to see larger numbers of disabled children in mainstream schools. Whilst the inclusion of children with SEN is regarded as part of the wider social inclusion agenda (Scottish Office, 1998a), the Government’s 29 social justice milestones do not refer specifically to education for disabled children (Scottish Executive, 2000c). In order for inclusive education to become a higher priority, a clearer definition of inclusion is needed so that progress towards this goal may be monitored. The Standards in Scotland’s Schools (etc) Act 2000 included a presumption that children with SEN would be educated in mainstream schools, unless this was not suited to their ability or aptitude, would incur unreasonable public expenditure or would not be compatible with the efficient education of other children. The wishes of parents and children must also be taken into account. The impact of this presumption needs to be monitored.
**Key differences in SEN policy between Scotland and England**

Since the late 1980s, and particularly the passage of the 1993 Education Act, there have been growing differences between SEN policy in England and Scotland. In some areas, parents and children have weaker rights in Scotland than in England. *The Code of Practice on the Identification and Assessment of Special Educational Needs* (DfE, 1994) obliged schools to register all children with SEN and adhere to school-based stages of assessment prior to statutory assessment. Statements must be issued within 18 weeks of their initiation. In Scotland, the *Manual of Good Practice in Special Educational Needs* (SOEID, 1998) suggests school-based stages of assessment and a six month time frame for the opening of a Record, but education authorities often do not follow this advice. In England, Statements usually quantify the provision which the LEA intends to make, whereas in Scotland Records of Needs rarely quantify provision. Finally, in England parents can take cases to the Special Educational Needs Tribunal where they disagree with the LEA’s educational provision, whereas in Scotland appeals are made to the Education Appeal Committee and thence to the Sheriff Court or to Scottish Ministers. Appeal Education Committees in Scotland have been criticised in a recent report by the Council on Tribunals on the grounds that their members lack training and insufficient attention is being paid to legal procedures. As a result, very few Scottish parents appeal (about 30 a year).

**Linkages with social work legislation**

The Children (Scotland) Act 1995 was introduced six years after equivalent legislation in England and Wales. Disabled children are identified as ‘children in need’. This category also includes children affected by disability in the family, including young carers (see Strathclyde Centre for Disability Research and the Centre for the Child and Society, 2000). Local authorities are obliged to provide services to meet the needs of such children. Services should ‘be designed to minimise the effect on a disabled child...of his disability’ and enable children ‘to lead lives which are as normal as possible’ (s23). Children must be consulted about all important decisions affecting their future. There are some key differences between English and Scottish Acts. Section 23 of the Scottish Act gives local authorities a duty to assess the needs of a disabled child, or a member of their family, if asked to do so. However, the Scottish Act only specifies that authorities must provide day-care, after-school care and holiday care, whereas the English Act stipulates a wider variety of services.

As in England, the Children (Scotland) Act places a corporate responsibility on authorities to meet the needs of children in need. Since Local
Government Reorganisation in 1996, Scotland has 32 unitary authorities and some have amalgamated education and social work or housing and social work. Stalker (2000) suggests that Scottish authorities are in a good position to instigate joint working between a range of agencies because of their size. However, Children’s Services Plans are still normally written by social work with limited input from other agencies. The Act clearly has implications for education, in terms of devising systems to take account of children’s wishes and ensuring services are meeting the needs of disabled children, their siblings, and children where there is a disabled adult family member. Cogan et al (1999) undertook a small-scale piece of research for Renfrewshire Council on services for children in families with a disabled family member. They found that education had taken little action to identify the population affected and ensure that their needs were being met.

A number of the Government’s social justice milestones concern child welfare issues, such as access to better childcare, improvement in educational standards, better health and the reduction of children living in low income households. Clearly, some of these milestones relate to the experiences of disabled children. Funding has been made available for a number of initiatives to tackle child poverty and exclusion. These include the New Opportunities Fund, the New Community Schools initiative and the Sure Start Programme. Evaluations are underway of these programmes. However the extent to which they are targeting the needs of disabled children is not clear.

**The post-16 policy framework**

Until relatively recently, little attention was paid to post-16 educational provision for disabled people (Closs, 1993, was one of the first publications in this area). The current focus on lifelong learning means that post-16 provision now has a higher profile, although academic literature is still relatively thin on the ground. Official statistics on participation of disabled students in higher education have been available from the Higher Education Statistics Agency for the past five years, but data on participation of disabled students in further education are still not available, although the Scottish Further Education Funding Council has plans to gather information from 2002. Statistical information on training provision for disabled people by Local Enterprise Companies (e.g. Skillseekers and Training for Work Programmes) is not published (see Chapter 3 for further discussion). Little is known about the participation of disabled young people in post-school training programmes. However, it appears that they are likely to be excluded from many training programmes which have outcome-related funded
because disabled people are seen as more expensive to train than others (Riddell et al, 1998).

The Further and Higher Education (Scotland) Act 1992 placed a duty on the Secretary of State (now Scottish Ministers) to ‘secure adequate and efficient provision of further education in Scotland’, and, in carrying out this duty, to ‘have regard to the requirements of persons over school age who have learning difficulties’ The term learning difficulties is used in the Act in a broad sense to include learning difficulties and barriers to learning. Similar duties apply in relation to people with learning difficulties in higher education.

The Scottish Executive provides additional funding for disabled students in further education colleges (known as premium funding) and this led to a rapid expansion of further education courses. Perhaps as a result of the employment-orientated mission of further education colleges, students with learning difficulties tend to be segregated from others, often using separate facilities from mainstream students (Riddell, Baron and Wilson, 2001). Further Education Colleges provide a range of short courses for adults with learning disabilities in day centres and the Scottish Executive’s Review of Services for People with Learning Disabilities The Same As You? (Scottish Executive, 2000a), recommended further expansion of such provision.

The Beattie Committee report Implementing Inclusiveness, Realising Potential (Scottish Executive, 1999c) considered all aspects of post-school provision for young people with additional support needs, a group which included young people with a range of disabilities and also disaffected young people. Central recommendations included:

- The appointment of a key worker for each young person to see them through the transitional period
- The establishment of Area Support Groups to oversee the activity of key workers and to co-ordinate the work of different agencies
- An emphasis on employment and employability
- More coherent and consistent approaches to assessment

Monitoring the implementation of these recommendations will be important over coming years, since young people with additional support needs are an extremely vulnerable group who are likely to become excluded unless they are given considerable help in entering and sustaining employment.

Since the early 1990s, there has been a significant expansion of higher education and a greater emphasis on the inclusion of previously marginalised groups. Disability was not in the original terms of reference of the Dearing and Garrick reports, which reviewed the funding of higher
education in the late 1990s. Partly due to pressure from Skill, the UK voluntary organisation for disabled students, a number of disability-related recommendations emerged from these reports including:

- the need to fund learning support in higher education institutions
- the need for the Institute of Teaching and Learning to include the needs of disabled students in their programmes
- the abolition of means-testing for the Disabled Students’ Allowance (DSA)

Institutions already have a responsibility under the Disability Discrimination Act 1995 to provide access to, or make reasonable adjustments to facilitate access to, their non-educational services. Many institutions have now begun to reassess their provision on this basis. The Quality Assurance Agency (QAA) Code of Practice for Students with Disabilities, launched in December 1999 and implemented from autumn 2000, takes institutions one step further by setting standards for provision and organisational practice. Unlike discrimination legislation, the QAA Code does not focus on the reaction of an institution to a particular student’s needs. Instead it requires an element of proactive change within institutions at all levels of their operation.

Further changes are likely in the near future. The SEN and Disability Act (Part IV of the DDA) opens institutions to possible accusations of discrimination if courses and premises are not accessible, or reasonable steps are not taken to make them so. Institutions must anticipate the needs of disabled students, for example, by implementing a strategic plan with the aim of making all buildings accessible. Alongside these developments go a number of other changes with implications for the sector. For example, the broadening of eligibility to the Disabled Students’ Allowance, intended to defer some of the additional costs of study accrued by disabled students, is increasing the number and range of disabled people in higher education. Likewise, the implementation of the Human Rights Act 1998 may have implications that have not yet been fully predicted. In 2001, for the first time the Scottish Higher Education Funding Council awarded premium payments to Scottish higher education institutions on the basis of the number of DSA claimants reported to the Higher Education Statistics Agency.

To summarise, there have been major changes in education policy for disabled people. Whereas in the past many disabled people were automatically excluded from mainstream education, there is now an expectation that they will be included. However, huge problems still exist, including inaccessible buildings, unmodified teaching programmes and lack of materials in alternative formats.
OFFICIAL STATISTICS

School statistics
The Scottish Executive conducts an annual schools census which collects data on all pupils in schools. The number and location of pupils with Records of Needs in particular authorities is recorded, as well as their principal learning difficulty. These data should yield information on the extent to which the move to include more disabled children in mainstream schools is actually happening. However, as we discuss below, the data are difficult to interpret partly because there are no firm criteria for opening a Record of Needs which has led to variation in local practice. Education authorities are now required to provide data on children with special educational needs as well as those with Records of Needs. The Scottish Executive does not specify any criteria for defining a child as having special educational needs, and it appears that this category is interpreted even more widely than the Record of Needs category.

Table 2.1 illustrates variability between authorities in the proportion of children for whom a Record of Needs is opened and who are identified as having special educational needs. With regard to the Record of Needs, whilst the Scottish average is about 2% the range is from 0.8% in East Dunbartonshire to almost 3% in Inverclyde. The Scottish average for pupils with SEN is slightly less than 5%. The range within this category is from 1.8% in East Dunbartonshire to almost 8% in Stirling. The extent to which children with SEN have Records of Needs is also variable. In South Lanarkshire, 59% of children with SEN have Records of Needs. In West Lothian, Records of Needs are only opened for 26% of such children.

One measure of inclusion is the extent to which children with Records of Needs are being educated in mainstream or special settings. Figure 2.1 refers to the percentage of children in mainstream and special schools according to the education authority in which they are educated, but where they do not necessarily live because they may travel across an EA border to school. This shows that Angus, East Lothian, Moray and Scottish Borders have 100% of recorded children in mainstream schools. Education authorities with low rates of mainstreaming are Glasgow (19%), West Dunbartonshire (33%) and Edinburgh (35%). However, these figures are misleading for a number of reasons:

• 27% of children in special settings do not have a Record of Needs. (However, such children are covered by the 1980 Act and therefore have a legal entitlement to a Record. Rights to appeal, to have a
### Table 2.1: Number and percentage of pupils with Records of Needs and special educational needs in Scottish education authorities

<table>
<thead>
<tr>
<th>Authority</th>
<th>No. of pupils with RoN</th>
<th>% of all pupils</th>
<th>No. of pupils with SEN</th>
<th>% of all pupils</th>
<th>% of SEN pupils with RoN</th>
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</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>15,643</td>
<td>1.9</td>
<td>37,702</td>
<td>4.8</td>
<td>41.5</td>
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<td>Aberdeen City</td>
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<td>1,656</td>
<td>5.6</td>
<td>44.1</td>
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<tr>
<td>Aberdeenshire</td>
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<td>1.7</td>
<td>2,064</td>
<td>5.6</td>
<td>32.9</td>
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<tr>
<td>Angus</td>
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<td>1.7</td>
<td>630</td>
<td>3.8</td>
<td>42.9</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>159</td>
<td>1.1</td>
<td>730</td>
<td>5.3</td>
<td>24.7</td>
</tr>
<tr>
<td>Clackmannan-shire</td>
<td>182</td>
<td>2.1</td>
<td>570</td>
<td>6.6</td>
<td>31.8</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>484</td>
<td>2.1</td>
<td>1,653</td>
<td>7.4</td>
<td>28.3</td>
</tr>
<tr>
<td>Dundee City</td>
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<td>957</td>
<td>4.4</td>
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<td>East Ayrshire</td>
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<td>905</td>
<td>4.7</td>
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</tr>
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<td>East Dunbarton-shire</td>
<td>151</td>
<td>0.8</td>
<td>360</td>
<td>1.8</td>
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<td>270</td>
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<td>East Renfrewshire</td>
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<td>5.9</td>
<td>29.9</td>
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<td>6.7</td>
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<td>Falkirk</td>
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<td>5.3</td>
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<td>Glasgow City</td>
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<td>Inverclyde</td>
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<td>2.8</td>
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<td>5.6</td>
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<td>Midlothian</td>
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<td>3.4</td>
<td>51.2</td>
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<td>Orkney Islands</td>
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<td>1.3</td>
<td>171</td>
<td>5.4</td>
<td>25.1</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>383</td>
<td>1.8</td>
<td>875</td>
<td>4.2</td>
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<td>Renfrewshire</td>
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<td>1,931</td>
<td>7.0</td>
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<td>Scottish Borders</td>
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<td>882</td>
<td>5.7</td>
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<td>2.0</td>
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<td>4.9</td>
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<td>Stirling</td>
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<td>West Dunbartonshire</td>
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<td>1.0</td>
<td>1,040</td>
<td>4.1</td>
<td>26.3</td>
</tr>
</tbody>
</table>

*Source: September 1999 School Census*
regular review and a multi-disciplinary assessment are removed in the absence of a Record of Needs).

- Some children are placed in special units but have their name on the register of a mainstream school. They may, however, be segregated from their peers.
- Figures refer to educating, not funding, authority. Edinburgh and Glasgow import children from surrounding areas because they have a historical legacy of special schools. As a result, it appears that some authorities make virtually no use of special placements, whilst others make very high use. Both sets of figures are distorted.

A further measure of the extent of inclusion is the proportion of the school population in special schools (see Figure 2.1). Across Scotland, 1.2% of the school population is placed in a special setting. This has changed little over the past decade, although there has been a slight increase over recent years. Authorities making high use of special schools are Glasgow (2.6%), Edinburgh (1.5%) and Aberdeen (1.6%). Authorities making little use of special schools are Angus (0.3%), Dumfries and Galloway (0.3%), Fife (0.4%) and Borders (0.4%). Caution is again needed in interpreting these figures because a child whose name is on a mainstream roll may in reality spend little time in a special unit attached to mainstream class. The general trend in Scotland is towards an increased use of special units and a decreased use of special schools.

To summarise, because the criteria for having a Record of Needs or SEN have never been clearly defined, the statistics are difficult to interpret and provide little firm evidence of a move towards inclusion. This is further complicated by uncertainty over what counts as a mainstream placement. Some rural areas like Scottish Borders and Dumfries and Galloway have either no or very few special schools. In these areas, children with SEN are often placed in special units attached to mainstream. They may spend almost all of their time in a segregated setting, but they are still counted as being in mainstream.
Figure 2:1 Pupils with Records of Needs in mainstream and special schools (%) in Scottish education authorities by educating authority

- W Lothian
- W Dunbarton
- Stirling
- S Lanark
- S Ayrshire
- Shetland
- S Borders
- Renfrew
- Perth & Kin
- Orkney
- N Lanark
- N Ayrshire
- Moray
- Midlothian
- Inverclyde
- Highland
- Glasgow
- Fife
- Falkirk
- Eilean Siar
- Edinburgh
- E Renfrew
- E Lothian
- E Dun
- E Ayrshire
- Dundee
- D & G
- C.manhan
- A & B
- Angus
- A.shire
- A City
- Scotland

% mainstream
% special

0 10 20 30 40 50 60 70 80 90 100

Percentage
Table 2.2: Number and % of pupils at special schools in Scotland by funding authority and % of special school pupils with Records of Needs

<table>
<thead>
<tr>
<th>Funding Authority</th>
<th>All pupils</th>
<th>RoN pupils</th>
<th>% of special school pupils with RoN</th>
<th>% of all pupils in special schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>9,347</td>
<td>6,852</td>
<td>73</td>
<td>1.2</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>474</td>
<td>342</td>
<td>72.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>418</td>
<td>287</td>
<td>68.7</td>
<td>1.1</td>
</tr>
<tr>
<td>Angus</td>
<td>61</td>
<td>54</td>
<td>88.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>82</td>
<td>51</td>
<td>62.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Clackmannanshire</td>
<td>92</td>
<td>87</td>
<td>94.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>76</td>
<td>46</td>
<td>60.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Dundee City</td>
<td>130</td>
<td>116</td>
<td>89.2</td>
<td>0.6</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>199</td>
<td>171</td>
<td>85.9</td>
<td>1.0</td>
</tr>
<tr>
<td>East Dunbarton-shire</td>
<td>192</td>
<td>112</td>
<td>58.3</td>
<td>1.0</td>
</tr>
<tr>
<td>East Lothian</td>
<td>80</td>
<td>63</td>
<td>78.8</td>
<td>0.6</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>112</td>
<td>105</td>
<td>93.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>905</td>
<td>557</td>
<td>61.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Eilean Siar</td>
<td>6</td>
<td>1</td>
<td>16.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Falkirk</td>
<td>362</td>
<td>307</td>
<td>84.8</td>
<td>1.7</td>
</tr>
<tr>
<td>Fife</td>
<td>217</td>
<td>173</td>
<td>79.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>2250</td>
<td>1804</td>
<td>80.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Highland</td>
<td>214</td>
<td>175</td>
<td>81.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>177</td>
<td>147</td>
<td>83.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Midlothian</td>
<td>155</td>
<td>95</td>
<td>61.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Moray</td>
<td>6</td>
<td>5</td>
<td>83.3</td>
<td>0.0</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>254</td>
<td>198</td>
<td>78.0</td>
<td>1.2</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>844</td>
<td>527</td>
<td>62.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Orkney Islands</td>
<td>20</td>
<td>6</td>
<td>30.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>126</td>
<td>98</td>
<td>77.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>364</td>
<td>310</td>
<td>85.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>28</td>
<td>22</td>
<td>78.6</td>
<td>0.2</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>23</td>
<td>19</td>
<td>82.6</td>
<td>0.6</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>101</td>
<td>65</td>
<td>64.4</td>
<td>0.6</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>723</td>
<td>53</td>
<td>73.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Stirling</td>
<td>126</td>
<td>92</td>
<td>73.0</td>
<td>1.0</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>224</td>
<td>121</td>
<td>54.0</td>
<td>1.4</td>
</tr>
<tr>
<td>West Lothian</td>
<td>306</td>
<td>163</td>
<td>53.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Outwith Scotland</td>
<td>38</td>
<td>34</td>
<td>89.5</td>
<td></td>
</tr>
</tbody>
</table>

Source: September 1999 Schools Census
Figure 2.2: Main impairment of pupils with a Record of Needs by gender (numbers)

Source: September 1999 Schools Census

Figure 2.3 provides information on the principal difficulties of children with Records of Needs by gender. Children with moderate learning difficulties represent the largest group (29%). Two thirds of pupils with Records of Needs are boys and they outnumber girls in every category. Gender differences are greatest in the areas of social and emotional difficulties (84% male), autistic spectrum disorder (84% male) and specific learning difficulties (dyslexia) (77% male).

Table 2.3 shows the number of pupils in special schools by gender. Overall there are twice as many boys as girls in special schools, but the ratio varies slightly between authorities. As noted above, boys are much more likely than girls to be identified as having social, emotional and behavioural difficulties, moderate learning difficulties and autistic spectrum disorders. There are probably both physiological and cultural reasons for these discrepancies, but little attempt has been made to understand the interplay of these variables. No Scottish Executive data are available in relation to ‘race’, social class and special educational needs.
### Table 2.3: Number of pupils at special schools in Scotland by funding authority and gender

<table>
<thead>
<tr>
<th>Funding Authority</th>
<th>All pupils</th>
<th>RoN pupils</th>
<th>% with RoN</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>9,347</td>
<td>6,852</td>
<td>73.3</td>
<td>6,267</td>
<td>3,080</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>474</td>
<td>342</td>
<td>72.2</td>
<td>324</td>
<td>150</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>418</td>
<td>287</td>
<td>68.7</td>
<td>298</td>
<td>120</td>
</tr>
<tr>
<td>Angus</td>
<td>61</td>
<td>54</td>
<td>88.5</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>82</td>
<td>51</td>
<td>62.2</td>
<td>58</td>
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<td>Clackmannanshire</td>
<td>92</td>
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<td>94.6</td>
<td>58</td>
<td>34</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>76</td>
<td>46</td>
<td>60.5</td>
<td>50</td>
<td>26</td>
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<td>74</td>
<td>56</td>
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<td>East Ayrshire</td>
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<td>134</td>
<td>65</td>
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<tr>
<td>East Dunbarton-shire</td>
<td>192</td>
<td>112</td>
<td>58.3</td>
<td>127</td>
<td>65</td>
</tr>
<tr>
<td>East Lothian</td>
<td>80</td>
<td>63</td>
<td>78.8</td>
<td>53</td>
<td>27</td>
</tr>
<tr>
<td>East Renfrewshire</td>
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<td>105</td>
<td>93.8</td>
<td>69</td>
<td>43</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>905</td>
<td>557</td>
<td>61.5</td>
<td>609</td>
<td>296</td>
</tr>
<tr>
<td>Eilean Siar</td>
<td>6</td>
<td>1</td>
<td>16.7</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Falkirk</td>
<td>362</td>
<td>307</td>
<td>84.8</td>
<td>245</td>
<td>117</td>
</tr>
<tr>
<td>Fife</td>
<td>217</td>
<td>173</td>
<td>79.7</td>
<td>130</td>
<td>87</td>
</tr>
<tr>
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<td>2250</td>
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<td>80.2</td>
<td>1532</td>
<td>718</td>
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<tr>
<td>Highland</td>
<td>214</td>
<td>175</td>
<td>81.8</td>
<td>148</td>
<td>66</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>177</td>
<td>147</td>
<td>83.1</td>
<td>119</td>
<td>58</td>
</tr>
<tr>
<td>Midlothian</td>
<td>155</td>
<td>95</td>
<td>61.3</td>
<td>116</td>
<td>39</td>
</tr>
<tr>
<td>Moray</td>
<td>6</td>
<td>5</td>
<td>83.3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>254</td>
<td>198</td>
<td>78.0</td>
<td>162</td>
<td>92</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>844</td>
<td>527</td>
<td>62.4</td>
<td>568</td>
<td>276</td>
</tr>
<tr>
<td>Orkney Islands</td>
<td>20</td>
<td>6</td>
<td>30.0</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>126</td>
<td>98</td>
<td>77.8</td>
<td>81</td>
<td>45</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>364</td>
<td>310</td>
<td>85.2</td>
<td>233</td>
<td>131</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>28</td>
<td>22</td>
<td>78.6</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>23</td>
<td>19</td>
<td>82.6</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>101</td>
<td>65</td>
<td>64.4</td>
<td>76</td>
<td>25</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>723</td>
<td>533</td>
<td>73.7</td>
<td>485</td>
<td>238</td>
</tr>
<tr>
<td>Stirling</td>
<td>126</td>
<td>92</td>
<td>73.0</td>
<td>76</td>
<td>50</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>224</td>
<td>121</td>
<td>54.0</td>
<td>156</td>
<td>68</td>
</tr>
<tr>
<td>West Lothian</td>
<td>306</td>
<td>163</td>
<td>53.3</td>
<td>200</td>
<td>106</td>
</tr>
<tr>
<td>Outwith Scotland</td>
<td>38</td>
<td>34</td>
<td>89.5</td>
<td>31</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: September 1999 School Census
Higher education statistics
When first degree students complete a central universities admissions form, they are asked whether they have a disability which may affect their studies in higher education. They are also given a chance to disclose a disability when they register. In 1998/99, 5% of undergraduate students disclosed a disability. The proportion has increased from 3.5% in 1996/97. A lower proportion of post-graduates and students on sub-degree courses disclose a disability. As noted earlier, a higher proportion of students disclose a disability (5%) than have a Record of Needs at school (2%). Given that students in higher education institutes (HEIs) represent about 35% of the population, and by definition do not include students with significant cognitive impairments, it is evident that disability is interpreted differently when people are asked to self-define. Table 2.4 shows that a higher proportion of first and sub degree students disclose a disability compared with post-graduates. This is probably for two reasons. Firstly, post-graduates complete an institutional rather than a centralised admissions form and may not be asked about their disability status. Secondly, post-graduates may be less aware of the Disabled Students Allowance and available institutional support and therefore may have less incentive to disclose a disability.

Table 2.4: HE Students in higher education institutions in Scotland 1998-99 by disability and level of study

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Postgrad</th>
<th>First degree</th>
<th>Sub degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>184,853</td>
<td>41,150</td>
<td>112,464</td>
<td>27,239</td>
</tr>
<tr>
<td>No known disability</td>
<td>157,277 (85%)</td>
<td>30,193 (67%)</td>
<td>101,890 (91%)</td>
<td>26,455 (92%)</td>
</tr>
<tr>
<td>Known disability</td>
<td>6,769 (4%)</td>
<td>823 (2%)</td>
<td>5,162 (5%)</td>
<td>67 (3%)</td>
</tr>
<tr>
<td>Information not sought, not known</td>
<td>20,807 (11%)</td>
<td>14,134 (31%)</td>
<td>5,412 (5%)</td>
<td>265 (5%)</td>
</tr>
</tbody>
</table>

Source: HESA (Higher Education Statistics Agency)

Table 2.5 presents numbers of disabled students in particular HEIs in Scotland. Institutions with relatively high proportions of disabled students are Royal Scottish Academy of Music and Drama (RSAMD) (9%), Scottish Agricultural College (7%) and Abertay (7%). Those with low proportions are Stirling (0%), Northern College of Education (2%), St Andrew’s College of Education (2%), Glasgow Caledonian (2%), Heriot-Watt (2%). A number of factors influence the extent to which disabled students are attracted to a
particular higher education institution in the first place, and subsequently whether they disclose a disability. Some institutions offering vocational courses such as education expect students to pass a medical declaring them fit to teach. The General Teaching Council has traditionally imposed very restrictive regulations on prospective teachers, and these are currently being reviewed. Medical courses, degrees in professions allied to medicine and engineering courses have also required prospective students to demonstrate that they would be able to work in a particular job without significant adaptations. These requirements are clearly at odds with the DDA, which requires employers to make reasonable adjustments to allow participation in employment. It may also be the case that students at universities such as Glasgow Caledonian, which attracts a relatively high proportion of non-traditional students, are less likely to have been identified as having dyslexia than students at St Andrews, which has a very high proportion of middle class students. At school, dyslexia is much more likely to be identified among middle class pupils (Riddell et al, 1994).

In Table 2.6, data on disability and gender are presented. Students with unseen disabilities make up the biggest category and of these 59% are women. Dyslexic students are the next largest group and here men outnumber women (58% male, 42% female). Whereas boys outnumbered girls in all categories of special educational needs at school level, in higher education the picture is more complex. A relatively small proportion of students disclose a mental health problem suggesting significant under-reporting in this category.

Information on students receiving the DSA is presented in Table 2.7. It is evident that a very small proportion receive this support in relation to the number of students in higher education. Only 8% of students with a known disability are in receipt of DSA, representing 0.3% of all students in higher education. There are no marked gender differences in terms of DSA claimants (Table 2.8).
Table 2.5: HE students in higher education institutions in Scotland 1998-99 by institution and disability

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total (=100%)</th>
<th>No known disability</th>
<th>Known disability</th>
<th>Information not sought, not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>93,281</td>
<td>90,532 (96%)</td>
<td>4,218 (4%)</td>
<td>4,551 (5%)</td>
</tr>
<tr>
<td>Abertay</td>
<td>4,201</td>
<td>3,454 (82%)</td>
<td>304 (7%)</td>
<td>443 (11%)</td>
</tr>
<tr>
<td>Edinburgh College of Art</td>
<td>1,692</td>
<td>1,590 (94%)</td>
<td>101 (6%)</td>
<td>1 (0%)</td>
</tr>
<tr>
<td>Glasgow School of Art</td>
<td>1,417</td>
<td>1,108 (78%)</td>
<td>54 (4%)</td>
<td>255 (18%)</td>
</tr>
<tr>
<td>Northern College of Education</td>
<td>3,375</td>
<td>2,807 (83%)</td>
<td>58 (2%)</td>
<td>510 (15%)</td>
</tr>
<tr>
<td>Queen Margaret College</td>
<td>3,704</td>
<td>3,530 (95%)</td>
<td>173 (5%)</td>
<td>1 (0%)</td>
</tr>
<tr>
<td>Royal Scottish Academy of Music and Drama</td>
<td>568</td>
<td>503 (89%)</td>
<td>52 (9%)</td>
<td>13 (2%)</td>
</tr>
<tr>
<td>St Andrew’s College of Education</td>
<td>1,340</td>
<td>1,073 (80%)</td>
<td>33 (2%)</td>
<td>234 (17%)</td>
</tr>
<tr>
<td>Robert Gordon University</td>
<td>10,586</td>
<td>10,260 (97%)</td>
<td>293 (3%)</td>
<td>33 (0%)</td>
</tr>
<tr>
<td>Paisley</td>
<td>10,800</td>
<td>9,866 (91%)</td>
<td>526 (5%)</td>
<td>408 (4%)</td>
</tr>
<tr>
<td>Glasgow Caledonian</td>
<td>15,117</td>
<td>14,785 (98%)</td>
<td>332 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Napier</td>
<td>11,870</td>
<td>11,380 (94%)</td>
<td>490 (4%)</td>
<td>219 (2%)</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>22,805</td>
<td>21,754 (94%)</td>
<td>1,051 (5%)</td>
<td>349 (2%)</td>
</tr>
<tr>
<td>Glasgow</td>
<td>20,726</td>
<td>19,876 (96%)</td>
<td>850 (4%)</td>
<td>50 (0%)</td>
</tr>
<tr>
<td>Strathclyde</td>
<td>23,170</td>
<td>22,467 (96%)</td>
<td>703 (3%)</td>
<td>7,185 (31%)</td>
</tr>
<tr>
<td>Aberdeen</td>
<td>12,234</td>
<td>11,650 (94%)</td>
<td>584 (5%)</td>
<td>1,319 (11%)</td>
</tr>
<tr>
<td>Heriot-Watt</td>
<td>13,525</td>
<td>13,216 (92%)</td>
<td>309 (2%)</td>
<td>7,595 (56%)</td>
</tr>
<tr>
<td>Dundee</td>
<td>12,610</td>
<td>12,181 (92%)</td>
<td>429 (3%)</td>
<td>602 (5%)</td>
</tr>
<tr>
<td>St Andrews</td>
<td>6,108</td>
<td>5,768 (93%)</td>
<td>340 (6%)</td>
<td>80 (1%)</td>
</tr>
<tr>
<td>Stirling</td>
<td>8,073</td>
<td>8,051 (81%)</td>
<td>22 (0%)</td>
<td>1510 (19%)</td>
</tr>
<tr>
<td>Scottish Agricultural College</td>
<td>932</td>
<td>867 (93%)</td>
<td>65 (7%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Source: HESA (Higher Education Statistics Agency)
Table 2.6: Students in higher education in HEIs 1998-99 by disability and gender

<table>
<thead>
<tr>
<th>Type of disability</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>101,364 (55%)</td>
<td>83,818 (45%)</td>
</tr>
<tr>
<td>No known disability</td>
<td>88,503 (56%)</td>
<td>69,072 (44%)</td>
</tr>
<tr>
<td>Dyslexia</td>
<td>686 (42%)</td>
<td>959 (58%)</td>
</tr>
<tr>
<td>Blind/partially sighted</td>
<td>86 (41%)</td>
<td>123 (59%)</td>
</tr>
<tr>
<td>Deaf/hearing impairment</td>
<td>217 (55%)</td>
<td>175 (45%)</td>
</tr>
<tr>
<td>Wheelchair user/mobility difficulties</td>
<td>136 (56%)</td>
<td>106 (44%)</td>
</tr>
<tr>
<td>Personal care support</td>
<td>7 (54%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Mental health difficulties</td>
<td>72 (47%)</td>
<td>81 (53%)</td>
</tr>
<tr>
<td>Unseen disabilities (e.g. diabetes, epilepsy, asthma)</td>
<td>1,967 (59%)</td>
<td>1,374 (41%)</td>
</tr>
<tr>
<td>Multiple disabilities</td>
<td>68 (53%)</td>
<td>61 (47%)</td>
</tr>
<tr>
<td>Other disability</td>
<td>376 (57%)</td>
<td>287 (43%)</td>
</tr>
<tr>
<td>Information not sought</td>
<td>1,752 (45%)</td>
<td>2,118 (55%)</td>
</tr>
<tr>
<td>Not Known</td>
<td>7,494 (44%)</td>
<td>9,456 (56%)</td>
</tr>
</tbody>
</table>

Source: HESA (Higher Education Statistics Agency)

Table 2.7: HE students in HEIs in Scotland 1998-99 by Disabled Students’ Allowance and level of study

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Postgrad</th>
<th>First degree</th>
<th>Sub degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>184,853</td>
<td>45,150 (24%)</td>
<td>112,464 (61%)</td>
<td>27,239 (15%)</td>
</tr>
<tr>
<td>No known disability</td>
<td>178,084</td>
<td>44,327 (25%)</td>
<td>107,302 (58%)</td>
<td>26,455 (17%)</td>
</tr>
<tr>
<td>Student has a disability and is in receipt of DSA</td>
<td>544</td>
<td>30 (5%)</td>
<td>447 (82%)</td>
<td>67 (13%)</td>
</tr>
<tr>
<td>Student has a disability and is not in receipt of DSA</td>
<td>1,870</td>
<td>211 (11%)</td>
<td>1,394 (74%)</td>
<td>265 (15%)</td>
</tr>
<tr>
<td>Student has a disability but information about DSA not known/not sought</td>
<td>4,355</td>
<td>582 (13%)</td>
<td>3,321 (76%)</td>
<td>452 (11%)</td>
</tr>
</tbody>
</table>

Source: HESA (Higher Education Statistics Agency)
Table 2.8: HE students in HEIs in Scotland 1998-99 by Disabled Students’ Allowance and gender

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>184,853</td>
<td>101,158 (55%)</td>
<td>83,695 (45%)</td>
</tr>
<tr>
<td>No Known disability</td>
<td>178,084</td>
<td>97,551 (56%)</td>
<td>80,533 (44%)</td>
</tr>
<tr>
<td>Student has a disability and is in receipt of DSA</td>
<td>544</td>
<td>275 (51%)</td>
<td>269 (49%)</td>
</tr>
<tr>
<td>Student has a disability and is not in receipt of DSA</td>
<td>1,870</td>
<td>1,039 (56%)</td>
<td>831 (44%)</td>
</tr>
<tr>
<td>Student has a disability but information about DSA not known/not sought</td>
<td>4,355</td>
<td>2,293 (53%)</td>
<td>2,062 (47%)</td>
</tr>
</tbody>
</table>

Source: HESA (Higher Education Statistics Agency)

REVIEW OF RESEARCH

There is a relatively extensive literature on Scottish education and disabled children, although the literature relating to disabled adults is somewhat sparse. In the following sections, we have provided a brief overview of the literature rather than an exhaustive account of the field.

Psychological and technological studies

Developmental psychology traditionally played a significant role in developing understanding of the learning of children with specific types of cognitive impairment, such as Down’s Syndrome, (Wishart,1996; Wishart and Manning, 1996). The CALL Centre at Edinburgh University engages in the analysis of technological developments and their application to the education of children and adults with special educational needs, for example, a publication by Kristofferson, Odor and Pinkerton (1995) focuses on the use of ‘smart wheelchairs’. Other research and development work focuses on the use of computer programmes and software to assist people who have writing difficulties. Technological aids and adaptions include spellcheckers, word predictors, talking word processors and portable writing aids. Some joint work has been undertaken between the CALL Centre and the Scottish Sensory Centre, for example, a publication by Ravenscroft and Carey (2000) dealt with modification of the Windows environment for visually impaired computer users.
**Studies of children with particular impairments**
Research into policy and provision for children and adults with particular impairments has been funded by the Scottish Executive, sometimes encouraged by the interest of voluntary organisations working on behalf of particular groups. For example, Reid (1998) conducted research on policy and provision for children with specific learning difficulties and Jordan and Jones (1997) investigated service provision for children with autism in Scotland. An evaluation of the Scottish Centre for Children with Motor Impairment based on principles of conductive education was conducted by Mackay et al (1996). This study questioned the relevance of conductive education to the Scottish educational context.

**Policy studies**
A number of Scottish studies have explored the experiences of disabled Scottish children (see the collection by Stalker and Robinson, 1998). Some of this work has made links with the sociology of childhood (Shakespeare and Watson, 1998) and children’s policy (Tisdall, 2001).

There is a growing interest in the nature and effectiveness of inter-agency partnerships for disabled children (see, for example, the collection of papers edited by Riddell and Tett, 2001). Closs (2000) and Lightfoot et al (2001) explored links between health and education and Clark et al (2001) investigated the impact of housing policy on the experiences of children with SEN and their families (the last two studies focus on the English policy context, but are relevant to Scotland). Mordaunt (2001) and Riddell et al (2000) reported comparative research on England and Scotland, exploring the differential implementation of SEN policy north and south of the Border which has tended to emphasise parental rights in England and professional discretion in Scotland.

**Research on post-16 education**
As noted earlier, there is less research on the post-16 sector than on compulsory education. In relation to higher education, Tinklin and Hall (1999) and Riddell (1998) analysed patterns of participation and experiences in Scotland. Closs (1993) edited a collection of papers exploring experiences of a range of post-school placements ranging from FE to Day Centres. Riddell and colleagues (2001) explored experiences of lifelong learning of people with learning difficulties at different points in the life cycle. Herd (1999a) reported an evaluation of a one-to-one tutor support service run by Accessibility Lothian, a group promoting inclusive education. Pearson (undated) conducted a study of young disabled people in transition also on behalf of Accessibility.
The wider equality context
Most research has focused on disabled adults and children, and links with other equality issues have not always been made. Lloyd (1996) edited a collection of papers exploring links between gender and education and Diniz (1999) looked at issues to do with ‘race’ and education of disabled children. Finally, links between social class, disability and education have not been extensively explored. Mcmillan (2001) conducted an internal study for Edinburgh City Council exploring the incidence of particular types on impairment in particular city schools. The study found that the greatest number of children with moderate learning difficulties and social emotional and behavioural difficulties were being educated in schools in the poorest areas. National research is needed to investigate whether this finding is replicated throughout the country.

Overall, it appears that the Scottish literature on the education of disabled children is mainly informed by psychological and technical approaches, although some policy analysis has been undertaken. Little is known about the experiences of disabled young people and adults and connections have not been made between disability and other aspects of an individual’s social identity such as gender, social class and ‘race’. The significance of geographical location has also been little explored.

ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES
The SEN and Disability Act 2001 has the potential to make a big difference to the education and future life chances of disabled adults and children. In higher education, the success of the new legislation may depend on the willingness of disabled people to challenge institutions failing to make reasonable adjustments. There may well be powerful disincentives to such challenges; students who have won a place in higher education may wish to focus on their studies, however difficult the circumstances, rather than invest a huge amount of energy in struggling for change which may benefit later students rather than themselves. However, if a student is unable to study because of an institution’s unwillingness to make reasonable adjustments, they will be forced to take legal action, however great the personal cost.

At school level, much will depend on education authorities’ willingness to make ‘reasonable adjustments’ to premises and schools’ willingness to make less resource-intensive adjustments. In addition, a critical factor will be the extent to which parents choose a mainstream placement for their...
child. If mainstream schools are perceived as unwelcoming environments with inadequate resources, parents may opt for special settings as the safer option. It is difficult to generalise about teachers’ attitudes to inclusion; many appear to approve in principle, but are nervous about the practicalities. However, pressures on institutions to maximise academic performance may mitigate against the wholehearted pursuit of inclusive education.

Some education psychologists in Scotland are currently lobbying to abolish the system of recording the needs of disabled students, arguing that professional discretion should be sufficient to ensure that children with SEN have their needs met. Experience suggests that improvements in the position of disabled people have depended on winning rights, rather than awaiting the benevolence of professionals. The Record of Needs is a contract between the education authority, the child and the parents, summarising the nature of the child’s difficulties and learning needs and stating what the Education Authority proposes to do to meet these needs. The Record also guarantees multi-disciplinary assessment and regular review, as well as a Future Needs Assessment. A current shortcoming of the Record of Needs is that it is often written in anodyne terms to avoid committing the education authority to providing additional resources. This is particularly problematic in the context of the SEN and Disability Act 2001, which does not place an obligation on the responsible body to provide aids and adaptations as a means of making reasonable adjustments, on the grounds that these are already stipulated under existing education legislation. To make the SEN and Disability Act work effectively in Scotland, the SEN framework needs to be tightened.

There are a number of ways in which parents and children appear to have access to greater rights in England and Wales than in Scotland. As described earlier, the process of assessment and drawing up a statement is more tightly regulated in England and there are more effective means of legal redress. The Special Educational Needs Tribunal will in future hear cases which are brought under the terms of the SEN and Disability Act 2001. In Scotland, the Scottish Executive’s advice on assessment and recording is often ignored and appeals procedures are both opaque and lack independence. In addition, there are as yet no firm plans to implement the planning measures of the SEN and Disability Act in Scotland. On a positive note, Scottish Ministers are currently considering legislation on planning and are also considering the implementation of a robust Tribunal system to deal with appeals to do with exclusions, special educational needs and disability discrimination. Public vigilance is essential to ensure that disabled adults
and children in Scotland enjoy the same rights to fair treatment in education as apply in other parts of the UK.

Finally, it is clear that in order to know whether progress is being made towards inclusion, far more reliable statistics are required on the placement of children with SEN. Clearer national criteria for opening Records of Needs and identifying children as having SEN would enable comparisons to be made between different areas and over time. The improvement of statistical information is part of the modernising government programme, however in the area of SEN some fundamental rethinking about the basis of statistical data is required before meaningful analysis can be carried out. Whilst it is relatively easy to interrogate SEN data in relation to gender, this is not the case in relation to social class and ‘race’. Improved statistical data in this area should therefore include information in relation to these two areas.

**Key research questions to be addressed include the following:**

- What is the impact of the SEN and Disability Act 2001 in Scotland and England and Wales on responsible bodies’ practices and on the experiences of disabled children, young people and adults? How are planning duties implemented? To what extent are responsible bodies making reasonable adjustments? How effective are the means of redress? Which disabled adults and children are covered by the legislation?
- What progress is being made towards including disabled children, young people and adults in mainstream education and training?
- To what extent are health, social work and education co-operating to make effective educational provision for children, young people and adults with the most significant difficulties?
- How are disabled people’s educational experiences affected by educational placement, geographical location, gender, ‘race’ and social class?
- How effectively are the proposals of the Beattie Committee on the transition of young people with additional support needs being implemented?
- How is the wider access agenda in higher education operating in relation to disabled people?
- To what extent do disabled people in Scotland have access to further, community and adult education and post-school training programmes?
INTRODUCTION

Disabled people of working age are much more likely than non-disabled people to be out of work and claiming benefits. In the Green Paper *New Ambitions for our Country: A New Contract for Welfare* (DSS, 1998), the Government made clear its commitment to ‘work for those who can, security for those who cannot’. The aim for those who are unable to work is to lead ‘a fulfilling life with dignity’ (DSS, 1998: 51). To achieve these goals, the Government stated that it would:

- Introduce effective civil rights for disabled people
- Remove the barriers to work and give active help to disabled people who wish to work
- Fundamentally reform Incapacity Benefit (IB) for future claimants; and
- Ensure the welfare state recognises the extra costs faced by disabled people

Employment and benefits policies remain reserved Westminster business and it is therefore much easier to obtain GB statistics on participation in Employment Service (ES) Disability Service programmes than statistics relating to Scotland alone. There has been very little research on the impact of ES programmes in Scotland (see the account of research by Wilson, Lightbody and Riddell, 2000, on the Scottish experience of the Employment Service’s Work Preparation Programme reported below). Evaluations of national initiatives, such as the first phase of the New Deal for Disabled People (Arthur et al, 1999) do not provide information on Scotland alone.

Although employment and benefits are reserved matters, the Scottish Parliament has a major influence in this area because it controls programmes to do with economic development. It is therefore extremely important to identify key areas for research and policy development, which may be pursued by Scottish agencies, as well as the Scottish data which needs to be disaggregated from UK/GB statistics.

CURRENT POLICY


Part II of the Disability Discrimination Act, some of which came into effect in December 1996, make discrimination in employment on grounds of disability unlawful. The law currently applies to firms employing more than 15 people and is about to be extended to small employers. This law is enforced...
through employment tribunals. Discrimination is defined as less favourable treatment delivered to a disabled person from that which a non-disabled person might expect to receive and there is a positive duty on employers to make reasonable adjustments. In order for discrimination to occur, the following conditions must apply:

- The treatment is given for a reason relating to the person’s disability and that reason does not apply to the other person and
- This treatment cannot be justified.

Employers must not discriminate against a disabled person in:

- Recruitment and retention of employees
- Promotion and transfers
- Training and development
- The dismissal process

The employment provisions of the DDA do not currently apply to members of the armed forces; prison officers; fire-fighters; employees who work wholly or mainly outwith Great Britain; employees on board ships; aircraft or hovercraft; police officers. Part II of the DDA also deals with discrimination against disabled people by trade organisations (including trade unions and employers’ organisations). These provisions came into force in December 1996 and the final provisions will come into effect in 2004.

Research was commissioned by the Department for Education and Employment eighteen months after the introduction of the DDA (Meager, 1999). A survey of employers, which formed part of this research, suggested that most thought that the DDA would result in ‘little change’. Of the 24 cases heard at Tribunal in Scotland between December 1996 and July 1998, only four were successful. Recent research provides more encouraging evidence that the DDA is having a significant impact on the way in which employers operate. A survey of 160 large and medium sized employers by the Industrial Relation Service (IRS Employment Trends 708, July 2000) showed that almost 80% of employers had reviewed job advertisements for disability discrimination, 79% had reviewed selection procedures and 73% access to buildings.

**The Employment Service’s Disability Services**

Within Scotland, local Disability Service Teams aim to provide a coherent employment, advice and assessment service accessed through Jobcentres. The Disability Service Teams (DSTs) comprise a group of professionals including the DEA and Occupational Psychologist. The function of these teams is to help disabled people obtain and keep jobs and help employers
develop good recruitment practices. Below, we briefly describe programmes run by the Employment Service in Scotland. Data are published by the ES on the number of participants and annual cost of each programme, but this information is not available for Scotland alone.

**The Work Preparation Programme** provides short placements (6-8 weeks average) designed to help disabled people move into the labour market or return after a break.

**Vocational Training** may be offered by residential training providers (RTPs) catering for people with a physical and/or sensory disability; a deteriorating medical condition; mental health problems; behavioural and learning difficulties. Six RTPs cater for people with a range of impairments, six cater for people with visual impairments and one is a specialist provider for people with a hearing impairment.

**The Access to Work** programme provides support to disabled people participating in mainstream employment. This includes help with the cost of getting work, aids and adaptations to equipment, computers or the workplace and with the cost of a support worker. The latter can take many forms e.g. driver, jobcoach, advocate, counsellor, communicator/note-taker for deaf people, personal reader/helper for those with a visual impairment and job designer.

**The Job Introduction Scheme** provides a weekly grant of £75 towards the cost of employing a disabled person for a trial period of employment (usually 6 weeks but with a possibility of extension to 13 weeks). The scheme is intended to act as an incentive to an employer who wishes to employ a disabled person but has doubts about their ability to cope with a particular job.

**The Supported Employment Programme** is delivered in partnership with local authorities, voluntary organisations and Remploy Ltd. The programme is intended to provide support, in mainstream or sheltered environments, for people facing complex barriers to obtaining employment. The Supported Employment Programme is currently being reviewed in order to move more people into mainstream employment, thus opening up opportunities for new recruits into the scheme.

In line with the emphasis on including people in mainstream employment, developments are underway within the Employment Service’s existing programmes. The National Disability Development Initiative sponsored the development of a range of innovative practice focused on assisting disabled
people enter and retain employment. For instance, in Scotland, Enable Services (the service arm of the Scottish voluntary organisation for people with learning disabilities and their parents and carers) piloted the use of supported employment within the context of its existing Work Preparation Programme.

Modernisation of the Supported Employment Programme took effect from April 2001. Whilst continuing to offer longer term support for those with severe and enduring disabilities, the modernised programme requires service providers to meet rigorous targets in moving disabled people into mainstream employment. As well as working with individual disabled people, programme providers encourage and support employers in making workplace adjustments to accommodate the needs of disabled workers, rather than relying on long term wage subsidy as they tended to do in the past. Other ES programmes, such as Access to Work and Work Preparation are currently being reviewed.

In line with the current concern with job retention, ministers from the Department for Education and Employment (DfEE), Department of Social Security (DSS), Department of Health (DoH) and other departments are currently planning joint projects which will test innovative approaches to job retention crossing health and employment boundaries. Employees in receipt of sick pay for six weeks will be targeted for intervention. Robust evaluation using random assignment methodology is planned, which will yield new data on factors influencing retention of target groups. This approach to evaluation is more rigorous than that which has been used in current evaluations of the New Deal for Disabled People (Arthur et al, 1999).

The New Deal for Disabled People and its extension
The New Deal for Disabled People (NDDP), managed jointly by the Department for Education and Employment and the Department of Social Security, was targeted at people of working age receiving incapacity benefits. The initiative piloted a number of innovations including:

- a PA service to assist people identify opportunities for employment and negotiate benefit issues,
- innovative schemes to test ways of helping people become more employable
- an information campaign to raise awareness among disabled people and employers of new and existing service provision
- research on the effectiveness of different approaches.

The recently announced extension to the New Deal for Disabled People
builds on a pilot in the Eastern Valleys in Wales, which used job brokers. Current government initiatives on employment for disabled people are focused on job retention and rehabilitation for those on Incapacity Benefits. Of this group, only 5% leave benefits for work each year. It is recognised that, for many who are unemployed and on sickness benefit, the critical window for return to work is within the first few weeks of becoming unemployed or sick. If people with an enduring or recently acquired impairment are to be helped to gain or retain employment, then new approaches are needed. Innovative approaches currently being developed involve a greater degree of inter-agency working and increased use of the private and voluntary sectors, particularly in the area of job brokerage. The NDDP extension aims to develop a network of job brokers offering disabled people guidance and support in finding employment and liaising with employers to create new opportunities for such people. This approach is similar to that adopted in the PA scheme in its emphasis on the need for a close mentoring relationship to assist in the transition from unemployment to work. Furthermore, the fact that job brokers are likely to be employed by private and voluntary sector agencies indicates a belief that social entrepreneurial activity does not sit easily within the culture of public sector organisations.

**Department of Social Security initiatives**

Until recently, the DSS and the DfEE operated relatively autonomously. It is now recognised that the benefits regime is critical in facilitating or presenting obstacles to entering and retaining employment. As part of its welfare to work programme, the Government has introduced a number of changes in the benefits system. Disability Working Allowance, which was widely criticised for its lack of uptake by disabled people, was replaced by a tax credit system. The period during which claimants could stop work and return to original benefits was increased from eight weeks to one year. More recently a partnership between the Benefits Agency and the Employment Service has resulted in the ONE initiative in which disabled people making a fresh claim for working age benefits have their employment and benefit enquiries dealt with by a PA with knowledge of services provided by both agencies. The project has been piloted in 12 areas. Closer links between Benefits Agency with the Employment Service signals a rapprochement between employment and benefits policies. In theory, the closer working relationship should allow for more flexible arrangements to support employment.

An additional important development has been the testing of a new Personal Capability Assessment to replace the All Work Test. In twelve pilot areas,
the examining doctor compiles an Incapacity Report for benefits purposes and a Capability Report for the PA. The Government wishes to change the situation whereby a person moving onto Incapacity Benefits was highly unlikely to return to the labour market. Whilst disabled people’s groups are generally in favour of creating a permeable interface between work and benefits, they recognise that individuals may feel very threatened if their benefits status is called into question.

During the 1980s, there was an unspoken policy of encouraging people to claim Incapacity Benefit (IB) rather than Unemployment Benefit in order to disguise the true level of unemployment. Subsequently, growth in the number of IB claimants rang Treasury alarm bells and access to this benefit was made much harder. However, disability benefits claims are unlikely to fall until discrimination against disabled people in the workplace is tackled.

**Interagency-working**

Most inter-agency initiatives have focussed on links between the Benefits Agency and the Employment Service. However, it is recognised that other agencies, in particular health, social work, transport and education, also play a critical role. Liaison between health care agencies and the Employment Service and Benefits Agency is under-developed (BSRM, 2000). In recognition of this, the Government launched the Welfare to Work Joint Investment Plans for disabled people as a means of bringing together the range of services currently affecting the working lives of disabled people. While this initiative is at an early stage of development, it has been criticised for not being specific enough as to which parts of the NHS should be involved and how the work will be funded (BSRM, 2000, p.14). The ways in which health agencies can liaise with employment focused agencies remains a key concern.

**Supported employment**

The voluntary sector in Scotland has over recent years played a key role in the development of supported employment opportunities for people at the margins of the labour market (N.B. voluntary sector supported employment schemes are quite different in mode of operation and philosophy from the Employment Service’s Supported Employment Programme as described above). With its origins in the United States, supported employment works on the principle that, with the help of systematic instruction provided by a job coach, and with natural support in the workplace, most jobs can be mastered by a person with learning disabilities or mental health problems. A key aspect of supported employment is that the disabled worker should be paid the going rate for the job. In the US, it has been claimed that disabled
people are much better off financially if they work. In Scotland, financial gains appear to be much more modest because of the operation of benefits regulations which mean that a disabled person is only allowed to earn a relatively small amount of money before jeopardising their entire benefits package, including their housing benefit (Riddell et al, 1999). As a result, most disabled people in Scotland work less than 16 hours a week, although many would like a much greater involvement in the labour market.

The Scottish Executive’s Learning Disabilities Review (Scottish Executive, 2000) envisages a significant expansion of mainstream employment opportunities for disabled people, and these moves are welcomed by organisations of people with learning difficulties. It should be noted, however, that some disabled people have reservations about supported employment, suggesting that such programmes may be patronising and ineffective.

**Local Enterprise Company Provision**

Local Enterprise Companies (LECs) are charged with securing economic development and improving quality of life. There are 22 LECs in Scotland, operating as limited companies. Thirteen are co-ordinated by Scottish Enterprise and nine by Highlands and Islands Enterprise. LECs are the principal delivery agents of the Government’s Skillseekers programme, which ostensibly offers a training place to all post-16 school leavers. LECs also fund Training for Work programmes for older disabled people. Whilst committed to tackling economic exclusion, LECs have to operate as businesses and therefore there is a built-in tension with regard to which groups of individuals are prioritised for investment through training programmes. Special Skillseekers programmes are run for young people endorsed as having special educational needs by local careers services. Whilst mainstream Skillseekers programmes stipulate that training providers must ensure that trainees are successful in attaining SVQ level 2 qualifications, less exacting targets are set for those on Special Skillseekers programmes. Research conducted by Riddell et al (1998) found that LECs varied in the number and quality of Special Skillseekers programmes offered, although national data are not published. In addition, Special Skillseekers programmes tended to be targeted at young people with social, emotional and behavioural difficulties rather than learning difficulties. The latter group were typically regarded as ‘social work’s responsibility’ because they were seen as unlikely to hold down a job. This policy is at odds with the policy objectives articulated in the Scottish Executive’s Learning Disabilities Review and in local Community Care Plans. Access to LEC training programmes requires closer scrutiny in the future.
OFFICIAL STATISTICS

In the following sections, we explore statistical evidence on the employment of disabled people drawn from the Labour Force Survey, the International Labour Organisation and the DSS Information Centre. In addition to providing some telling comparisons between the disabled and non-disabled population and disabled men and women of different ages, the statistics reveal the complexity of calculations relating to employment and unemployment rates.

Employment statistics

Figure 3.1 tells an interesting story about the labour market participation of disabled and non-disabled people.

Figure 3.1: Disabled people of working age in the labour market, Scotland 1999

Sample size: Disabled = 778,780
Not Disabled = 2,311,066

Note: Approximately 5,000 of the working age population is missing from the above analysis.

Disabled people answered yes to “Do you have any health problems or disabilities that you expect will last for more than a year?”

Source: Labour Force Survey: Spring to Winter 1999
First, it is clear that disabled people are less likely to be employed than non-disabled people (48% employment rate for disabled people compared with 80% for non-disabled people, including those who are self-employed). A much higher proportion of disabled people have given up any hope of work; 32% of disabled people say that they do not want or are unable to work, compared with 11% of non-disabled people. A higher proportion of disabled than non-disabled people are among those who would like to work but are not available or are not seeking employment. 15% of disabled people fall into this category, sometimes referred to as ‘discouraged workers’, whilst only 2% of non-disabled people place themselves within this group. The NDDP has been specifically targeted at ‘discouraged workers’, that is people who would welcome the opportunity to work but have been put off by a range of barriers including lack of suitable jobs, discriminatory attitudes, insufficient support in the workplace and perverse incentives created by the benefits system.

*Figure 3.2: Employment rate of men of working age population by disability status, Scotland 1999*

Sample size Disabled = 1,665  
Sample size Not Disabled = 4,536  
*Source: Labour Force Survey: Spring to Winter 1999*  
Notes: Employment rate = Those who are in employment expressed as a
percentage of all persons of working age. Disabled people answered yes to “Do you have any health problems or disabilities that you expect will last for more than a year?”

**Figure 3.3: Employment rate of women of working age population by disability status, Scotland 1999**

![Bar chart showing employment rates for women of working age by disability status in Scotland 1999.](image)

Sample size Disabled = 1,500
Sample size Not Disabled = 4,705
Source: Labour Force Survey: Spring to Winter 1999
Notes: Employment rate = Those who are in employment expressed as a percentage of all persons of working age.

1 Disabled people answered yes to “Do you have any health problems or disabilities that you expect will last for more than a year?”

Figures 3.2 and 3.3 allow us to compare the employment rates of disabled and non-disabled men and women at different ages. Among the non-disabled population, men have somewhat higher labour market participation than women. For non-disabled men and women, the highest employment rate is around 40-44 and then begins to decline. For disabled men and women, the rate of employment is markedly less than for the non-disabled population, but in relation to age the pattern is less clear.
Table 3.1: Economic activity of working age people by gender according to different definitions of disability: Scotland 1999

<table>
<thead>
<tr>
<th></th>
<th>Economic activity rate (%)</th>
<th>Employment rate (%)</th>
<th>ILO Unemployment rate(%)</th>
<th>All Persons of working age (thousands)</th>
<th>Base Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>All long-term disabled¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>53.6</td>
<td>47.4</td>
<td>11.7</td>
<td>779</td>
<td>3,165</td>
</tr>
<tr>
<td>Men</td>
<td>55.6</td>
<td>48.0</td>
<td>13.6</td>
<td>419</td>
<td>1,665</td>
</tr>
<tr>
<td>Women</td>
<td>51.4</td>
<td>46.7</td>
<td>9.2</td>
<td>359</td>
<td>1,500</td>
</tr>
<tr>
<td>Work-limiting disabled²</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>36.5</td>
<td>29.4</td>
<td>19.6</td>
<td>504</td>
<td>2,056</td>
</tr>
<tr>
<td>Men</td>
<td>37.6</td>
<td>29.2</td>
<td>22.4</td>
<td>274</td>
<td>1,094</td>
</tr>
<tr>
<td>Women</td>
<td>35.3</td>
<td>29.6</td>
<td>16.0</td>
<td>230</td>
<td>962</td>
</tr>
<tr>
<td>DDA current disabled³</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>37.5</td>
<td>31.9</td>
<td>14.9</td>
<td>484</td>
<td>1,981</td>
</tr>
<tr>
<td>Men</td>
<td>36.9</td>
<td>30.8</td>
<td>16.5</td>
<td>256</td>
<td>1,025</td>
</tr>
<tr>
<td>Women</td>
<td>38.1</td>
<td>33.1</td>
<td>13.1</td>
<td>229</td>
<td>956</td>
</tr>
<tr>
<td>Not long-term disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>84.8</td>
<td>79.3</td>
<td>6.5</td>
<td>2,311</td>
<td>9,061</td>
</tr>
<tr>
<td>Men</td>
<td>90.3</td>
<td>83.9</td>
<td>7.2</td>
<td>1,181</td>
<td>4,356</td>
</tr>
<tr>
<td>Women</td>
<td>79.0</td>
<td>74.6</td>
<td>5.6</td>
<td>1,130</td>
<td>4,705</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey: Spring to Winter 1999

1 Long-term disabled people answered yes to “Do you have any health problems or disabilities that you expect will last for more than a year?”
2 Work-limiting disabled people are people who have a long-term disability which affects the kind or amount of paid work they might do.
3 DDA (Disability Discrimination Act) current disabled people are people who have a long-term disability which substantially limits their day-to-day activities.

Note: Economic activity rate = Those who are in employment or ILO unemployed expressed as a percentage of those economically active plus those outside the labour market of working age.
Employment rate = Those who are in employment expressed as a percentage of all persons of working age
ILO unemployment rate = the International Labour Organisation recommended measure, which counts as unemployed those of working age who are without a job, are available to start work in the next 2 weeks, and have been seeking a job in the last 4 weeks or are waiting to start a job already obtained; expressed as a percentage of the economically active.

Table 3.1 compares the employment and unemployment rates of disabled and non-disabled people and disabled men and women according to different definitions of disability and relationship to the labour market. As noted in the Introduction, a higher proportion of working-age people have long-term health problems than are disabled under the DDA definition (having a long term disability affecting day-to-day activity). 25% of the working age population fall under the first definition whilst 16% fall under the DDA definition. Under the DDA definition of disability, about a third of disabled women and men are in employment. By comparison, slightly less than half of people who report that they have an enduring health problem or disability are in employment. The ILO unemployment rate varies from 12% for all long-term disabled people, to 15% for people who fall under the DDA definition to nearly 20% for people who have an enduring and work-limiting disability. Under all definitions, differences between disabled women and men in terms of labour market participation are quite small compared with the general population, where men have significantly higher economic activity, employment and ILO unemployment rates.

Benefits and Income Statistics
Table 3.2 reports numbers of recipients of disability benefits in Scotland. The number of people receiving Incapacity Benefit, normally claimed after a period of participation in the labour market, rises steadily with age; in the 55-59 age group 42,800 people are in receipt of Incapacity Benefit and in the working age population 193,300 people are on IB. There are 3,090,000 people of working age in Scotland, so IB claimants represent about 6% of the working age population. A much lower proportion of the working age population receive Severe Disablement Allowance (42,800). Disability Living Allowance, available to people of any age, is claimed by 235,000 people. A very small number of people claim the Disabled Person’s Tax Credit (2,200).
Table 3.2: Recipients of disability benefits in Scotland, 2000

<table>
<thead>
<tr>
<th>Age</th>
<th>Incapacity Benefit</th>
<th>Severe Disablement Allowance</th>
<th>All Awards</th>
<th>Care Mobility</th>
<th>Care &amp; Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>193.3</td>
<td>42.8</td>
<td>235.0</td>
<td>168.3</td>
<td>209.2</td>
</tr>
<tr>
<td>Under 20</td>
<td>0.1*</td>
<td>2.3</td>
<td>23.8</td>
<td>22.5</td>
<td>15.3</td>
</tr>
<tr>
<td>20-24</td>
<td>2.3</td>
<td>4.0</td>
<td>5.0</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>25-29</td>
<td>6.2</td>
<td>3.5</td>
<td>7.1</td>
<td>5.8</td>
<td>6.2</td>
</tr>
<tr>
<td>30-34</td>
<td>10.8</td>
<td>4.5</td>
<td>10.0</td>
<td>8.0</td>
<td>8.7</td>
</tr>
<tr>
<td>35-39</td>
<td>16.3</td>
<td>4.7</td>
<td>13.9</td>
<td>10.8</td>
<td>12.3</td>
</tr>
<tr>
<td>40-44</td>
<td>20.2</td>
<td>4.0</td>
<td>15.3</td>
<td>11.5</td>
<td>13.7</td>
</tr>
<tr>
<td>45-49</td>
<td>23.5</td>
<td>4.4</td>
<td>17.0</td>
<td>12.3</td>
<td>15.5</td>
</tr>
<tr>
<td>50-54</td>
<td>35.2</td>
<td>4.6</td>
<td>23.9</td>
<td>16.7</td>
<td>21.7</td>
</tr>
<tr>
<td>55-59</td>
<td>42.8</td>
<td>4.8</td>
<td>28.6</td>
<td>20.0</td>
<td>26.2</td>
</tr>
<tr>
<td>60 &amp; over</td>
<td>35.8</td>
<td>6.0</td>
<td>90.6</td>
<td>56.5</td>
<td>85.1</td>
</tr>
</tbody>
</table>

Source: DSS Information Centre

* = taken from a small no. of sample cases so should be used only as an indication of the present situation.
1 Figures expressed in thousands and rounded to the nearest hundred.
2 Information taken from a 5% sample of the benefit computer system and excludes a small number of cases held clerically.
3 Information taken from a 5% sample of the benefit computer system.
4 Information taken from a 100% sample of the benefit computer system.

Figure 3.4 presents data on the income for households with a disabled person living in them, and Figure 3.5 for households without a disabled person living with them.
1 Disabled people identified by the question: “Do you or anyone else in the household have any long-standing illness, health problem or disability that limits your/their daily activity or the kind of work that you/they can do?”

The SHS results are weighted to take account of differences in selection probabilities. As with all such surveys, factors such as sampling variability and non-response bias may affect the results.
A third of households including a disabled person had an income of £6,000 or less, and a further third had an income of £6,000 - £10,000. Twelve percent had an income of £10,000 - £15,000. According to the Scottish Household Survey, 19% of households where no one had a disability earned more than £20,000. In households including a disabled person, only 6% had an income of more than £20,000. Clearly, the upshot of low employment rates, low levels of benefits and the additional costs of disability is that the majority of disabled people, or households which include a disabled person, are living in poverty. Since poverty is the major cause of social exclusion (Burchardt, 2000), disabled people should therefore be at the centre of the Government’s social inclusion agenda. In order to tackle poverty, efforts are needed to address discrimination in employment, low pay and low levels of benefit.

**REVIEW OF RESEARCH**

Although there is a growing body of literature on disability and employment, most of this research does not relate specifically to Scotland. A small number of key studies are summarised below.

Meager et al (1998) conducted GB research on the participation of disabled people in employment, providing baseline data to assist in the monitoring of the effect of employment provisions of the DDA, some of which came into effect in December 1996. The study presented findings from a national survey of 2,000 disabled people of working age (men aged 16-64; women aged 16-59) who have a long-term disability or health problem, and those who have had such a disability, in line with the definition of disability in the DDA. They found that:

- Unemployed disabled people generally have a positive outlook on getting work. They agree strongly that getting a job is important to them (64% agree strongly, and 29% agree with this statement) and that they will continue to look for a job.

- Over a quarter of people who left their job because of their disability say that adaptations would have enabled them to stay in work; but less than one in five of this group say they were offered such changes.

- One in six disabled people (16%) who are or have been economically active say that they have experienced discrimination or unfair treatment in a work-related context.

- Just under half (47%) of economically inactive disabled people who see themselves as being able to work say they would like a paid job.

- Disabled people in employment are more likely to work in manual and lower skilled occupations.
• Disabled people from ethnic minorities are more likely to be unemployed than their white counterparts.
• At £196 per week, the average take home pay of disabled employees in 1998 was lower than that of non-disabled employees (£212).

A follow-up study on Disabled Jobseekers (Goldstone and Darwent, 2000) re-interviewed the small group of individuals surveyed in 1996 who were unemployed but looking for work. The aim of the follow-up study was to investigate the job-search activities and perceptions of their experiences over the two and a half years since the implementation of the DDA. The following findings were reported:
• The follow-up of 83 unemployed disabled respondents from the baseline survey revealed that 39% were unemployed but still looking for work and 29% were not working and not looking for work.
• Compared with other respondents, those in employment tended to be more optimistic about finding another job although few of this group were actively seeking employment. Their perceptions of employers’ attitudes were also more positive.
• The majority of respondents who were presently inactive stopped looking for work because of health reasons. Their optimism and confidence about employment prospects were low.
• The majority of respondents had little confidence in the DDA. Some believed that employers could evade it and that it was unlikely to impact on their situation.
• There was fairly low awareness among respondents of the New Deal except among the small number of respondents who had been involved in the programme. Some others had broad ideas of what was involved.
• The Jobcentre was a key organisation for advice. It was well regarded overall although there was some criticism. Specialist advisers based at the Jobcentre (specifically the DEA) were particularly highly valued because of their greater knowledge and understanding of disability issues.
• There was a mixed attitude to education and training - this was often influenced by experience in that those who have received training base their perceptions on whether they believe it was or was not influential in helping them find and keep work.

Whilst such studies provide useful information at a GB level, there is a need to compare data from England, Wales and Scotland to investigate whether different economic and geographical conditions produce different patterns of labour market activity.
Some evaluations of existing programmes are available. For example, Lakey and Simkins (1994) analysed the structures, monitoring and effectiveness of the Employment Service’s Work Preparation programme. They concluded that the shift from specialised, but geographically remote, training centres had led to greater flexibility and responsiveness to needs at the local level. On the other hand, people with highly specific impairment-related needs were often not catered for adequately by local training providers with generic, rather than specialist, knowledge.

Early evaluation of the NDDP’s Personal Adviser Service pilot scheme (Arthur et al, 1999) provides a broad overview of some of the programme’s strengths and weaknesses. The scheme commenced in October 1998. It was to run for two years and was initially implemented in six areas where the ES delivered the PA Service. It was extended to six other areas in April 1999 where it was delivered by partnerships that included private and voluntary sector organisations. Findings included the following:

• Uptake of the scheme was low (only 3% of people on IB responded to the invitation letter) but almost as many again came through in other ways.
• Participants were on average younger and better qualified than non-participants, and more likely to have a partner in paid work and access to transport.
• Participants had typically had their impairment or health problem for less time than non-participants and had consequently not been without work and on benefit for so long.
• Compared with non-participants, participants were more likely to have worked in the past and more were actively seeking work.
• With certain reservations, high levels of satisfaction were recorded among clients who participated in the PA schemes.
• There was evidence that the PA scheme was not yet salient among disabled people or employers and association with other New Deal programmes might carry negative connotations.
• Many PA schemes were located in Jobcentres. These offered a good working base for PAs, but might be seen as threatening by some clients.
• PAs had often worked before as Disability Employment Advisers (DEAs). In some areas there were problems recruiting enough suitable candidates.
• PAs expressed concern about the growing emphasis on employment outcomes and away from intermediate outcomes (e.g. growth in confidence, employability etc) for the PA Service.
• Links between the Benefits Agency and Employment Service were
generally positive, particularly when the scheme was located in Employment Service’s premises. However, some PAs felt their contact with the Benefits Agency had triggered some reviews of clients’ benefit entitlement.

- No information was provided on the number of NDDP clients obtaining work at the end of their training period.

Wilson et al (2000) provide one of the few studies investigating the experience and outcomes of an Employment Service programme in Scotland. The study investigated perceptions of the programme held by Employment Service personnel and by clients participating in a scheme run by a voluntary organisation provider and analysed Scottish data on the nature of Work Preparation participants and their outcomes. Findings included the following:

- ES personnel had a generally positive view of the Work Preparation Programme, regarding it as likely to improve people’s employability as well as helping a significant proportion to obtain work.
- Between January 1998 and June 1999, 2,381 clients participated in the Work Preparation programme. Two thirds of participants were male.
- Across the country, there was considerable variation with regard to opportunities for clients with particular impairments. People with mental health problems were least likely to participate in Work Preparation.
- Overall, 45% of those participating in Work Preparation had a positive outcome, defined as participation in another ES programme, training, education or employment 13 weeks after the end of the placement.
- 20% of participants were employed at the end of their placement, many of these in part-time work.

The majority of clients had positive experiences of the Work Preparation programme, but for those with higher support needs the placement was too short and insufficient support was available.

Overall, despite the utility of GB wide research, there are insufficient studies of disabled people’s experience of employment in Scotland. This is particularly important in terms of monitoring the specific impact of the DDA. Scotland has particular conditions which are uncommon in the rest of the UK (e.g. concentration of poverty in Glasgow, large areas of low population in the north west, a different minority ethnic population from the rest of the UK). Because equal rights and employment are both reserved matters, the DfEE has funded GB research rather than research which explores the particularities of policy implementation in different part parts of GB. There
is a strong argument that, post-devolution, there is a requirement for information which informs disabled people, politicians and local policy makers about the implementation of the DDA in Scotland and allows for comparisons across GB.

ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES

To summarise, employment is seen as a key element in social inclusion and the fact that such a high proportion of disabled people are excluded from the labour market is a cause for concern. Traditionally, employment-focused programmes have not been very successful in helping disabled people to access employment or hold on to a job at the onset of a disabiling condition. The Government wishes to develop good and innovative work in this area. New developments include a growing focus on job brokerage, drawing on practices originally developed in the US. Work entrepreneurs are likely to be employed by the private and voluntary sectors rather than the public sector. There is also a push for much greater use of inter-agency working, and a recognition that health and employment services need to work together to assist people who have experienced sudden trauma (e.g. head injury, stroke, heart problems) as well as those with back pain and stress. There is, however, a dearth of Scottish-based research on particular employment focused programmes and government initiatives. Research funded by the DfEE and the DSS has a GB focus, and, whilst providing a useful overall picture, does not allow for comparisons to be made across different parts of GB. Such information is important in informing Scottish and Westminster ministers on the implementation of the DDA in Scotland, and to allow cross-GB comparisons to be made.

The data presented in this chapter also show clearly that, as a result of low employment rates and low levels of benefit, disabled people and their families are very likely to be living in poverty. The Government has focused its attention on getting disabled people, particularly those on Incapacity Benefit into employment. Far less attention has been focused on improving the levels of benefit for those who cannot work. Tackling poverty for this group must involve increasing benefits.

The Government is committed to extending the employment-related provisions of the DDA in 2004. All employers, including small businesses who were previously exempt, will be expected to make ‘reasonable adjustments’ for disabled people. In addition, police officers, fire fighters and prison officers will be covered by the Act, although the armed services
will continue to be exempt. The definition of disability will be extended to include people who have cancer and those who are HIV positive to prevent employers discriminating against these groups. These measures have the potential to enhance significantly the rights of disabled people and their implementation in Scotland, as well as in the wider GB context, should be monitored. However, unless rights for workers are complemented by higher rates of benefits for disabled people who are unable to work, poverty will continue.

This review of policy, statistics and research unearthed little data on regeneration strategies targeted at disabled people, an area of policy devolved to the Scottish Parliament. Social Inclusion Partnerships and Local Enterprise Companies contacted during the course of the research confirmed that most of their programmes did not have a prime focus on disabled people. In the future, those responsible for planning local regeneration strategies in Scotland need to pay much greater attention to the distinctive needs and difficulties of disabled people and ensure that their activities complement UK employment and social security initiatives.

**Key research questions to be addressed include the following:**

- In Scotland what is the impact of UK employment and social security initiatives aimed at assisting disabled people into employment? What do UK comparisons reveal about their differential effects?
- What impact do employment-focused measures have on particular groups of disabled people in Scotland in relation to age, geographical location, ‘race’ and social class?
- What is the impact of local economic regeneration strategies on disabled people?
- To what extent do local economic regeneration strategies complement UK employment and social security initiatives?
- What measures are likely to have a positive impact on raising the household income of disabled people in Scotland?
INTRODUCTION

This section of the report will focus on policy, official statistics and research relating to health and social care as they are experienced by disabled children and adults. The relationship between the NHS, local authorities as providers of services, and disabled people is complex. Some people are born with an impairment or develop an impairment later in life due to accident or illness. However, this does not mean that they are permanently either ‘ill’ or in need of ‘care’. In addition, people who require assistance with daily activities may not be ill. The conflation of illness and disability leads to the mistaken idea that disabled people are dependent on others. Whilst some disabled people may require assistance in some areas of their lives, this does not imply dependency and people who use assistance may well provide care for others (e.g. disabled parents). Shakespeare (2000) has recently analysed the colonising and disempowering effects of care as it has traditionally been construed, suggesting that the idea of interdependence is more helpful in understanding the reciprocal nature of most people’s relationships. It is probable that many of us will experience disability at some point in our lives, particularly as we get older. We may also find ourselves temporarily disabled if we spend time in hospital (SEHD, 1999). The population who may be described as disabled from the point of view of health and social services is thus very extensive. According to Scottish Executive Health Department data, in the year 2000 over 800,000 people in Scotland had some sort of disability (about a fifth of the population).

Because of the nature of health services in the UK, which have traditionally seen their role as diagnosing and treating illness, much policy in relation to health services for disabled people has been impairment specific. The understanding of disabled people as a broad group experiencing particular forms of social and economic oppression is not widely reflected in the way in which health personnel view the world. NHS priorities still tend to be framed in terms of reducing the incidence of specific illnesses (e.g. stroke, coronary heart disease) and accidents and traumas, including suicide. Discouraging behaviours likely to damage health (e.g. smoking, alcohol and drug abuse) and encouraging health-promoting behaviours (e.g. breast-feeding, taking exercise and improving diet) are also NHS priorities. Illnesses and health damaging behaviours are clearly linked with the onset of impairment, for instance, in Scotland stroke is the largest single cause of impairment in adults. However, the focus on illness, accident and health-damaging or
promoting behaviour means that understandings of disability as a political category or social division are not well developed. There is a strong public health research tradition in Scotland, which has focused on the links between social disadvantage and patterns of morbidity and mortality. This work has again focused on illness rather than disability, but is useful in illuminating the way in which impairments are created within capitalist societies, a key theme of the social model of disability. We would hope that, as the government’s social inclusion strategy bites, there will be a decline in the association between poverty and impairment, and this needs to be closely scrutinised in the future.

CURRENT POLICY

Health policy
The election of a Labour Government in 1997 saw a change of emphasis in social policy. For example, the White Paper, *Designed to Care: Renewing the National Health Service in Scotland*, (Scottish Office, 1997b) set out the new structure for the NHS in Scotland to come into operation in April 1999. Proposals included a shift from competition to co-operation with the abolition of GP fundholding. The role of the 15 Health Boards in determining local strategy, monitoring and implementation remained unchanged. Each Health Board was expected to prepare rolling five-year Health Improvement Programmes (HIPs) covering issues such as health promotion, needs assessment and resource allocation. Each health board area would comprise a number of Primary Care Trusts (PCT) and Acute Hospital Trusts (AHT) which would be responsible for putting the plans into action. In addition to responsibility for general practice, PCTs are responsible for operating some hospital services. GP practices were expected to form Local Health Care Co-operatives, which would enable them to pool expertise and services.

In 1998 a Green Paper *Working Together for a Healthier Scotland* (Scottish Office, 1998b) sought views on the Government’s strategy for improving health in Scotland. This paper heralded a more holistic approach to health, focussing particularly on environmental problems, social exclusion, and inequalities. Following a period of consultation the White Paper *Towards a Healthier Scotland - A White Paper on Health* was published (Scottish Office, 1999a). The paper asserted that:

> Good health is more than not being ill; we need to work on a broad front to improve physical, mental and social well being, fitness and quality of life. The benefits which accrue will be measured not just in deaths postponed, but in relief from pain, fear and disablement.
The policies outlined in *Towards a Healthier Scotland* were part of a raft of measures introduced to tackle inequalities and improve life circumstances. Other measures included the creation of the Social Inclusion Partnerships, the New Deal for Communities programme, and the wider Social Inclusion Strategy. The co-ordinated approach was adopted by the Executive in *Making it Work Together* (Scottish Executive, 1999d) and the Minister for Health and Community Care undertook the task of promoting cross-departmental working with the aim of tackling inequalities and promoting health. A number of targets focusing on health and lifestyles have been set including reductions in heart disease, cancer, smoking and alcohol misuse. The White Paper also identified funds to cover the Scottish Needs Assessment Programme to develop guidance on Health Impact Assessment (HIA). HIA is a way of evaluating the probable effects of new policies and initiatives on health for particular groups (including disabled people) and the wider population by looking at evidence derived from pilot schemes.

Recent interest in the allocation of resources within the NHS in Scotland, reflecting the government’s commitment to ensure that distribution reflects local population needs (The Arbuthnott Report, Scottish Executive 2000g; Designed to Care, Scottish Office, 1997b), have drawn attention to the difficulty of ensuring equality of services for people in different geographical areas and sectors of society. The *National Review of Resource Allocation for the NHS in Scotland* (Scottish Executive, 2000g) recommended a formula based on four key elements:

- a) Size of each health board
- b) Population profile in terms of age and sex,
- c) Relative morbidity and level of deprivation
- d) Population distribution in terms of density and distance from main centres of provision.

In Scotland there are considerable variations in all four elements amongst the 15 Health Board Areas making the goal of ‘equitable access to healthcare’ problematic.

In addition to the general thrust of health policy in Scotland described above, the NHS in Scotland has sought to ensure that as an organisation it is adhering to the requirements of the DDA both as a service provider and an employer. The document *Equality for Disabled People in the NHS in Scotland* (Scottish Executive Health Department, 1999) provided advice to people working at all levels in the NHS in Scotland on improving the standard of support and care offered to disabled people.
The Disability Rights Task Force’s recommendations
As noted earlier, in December 1999 a report covering a wide range of issues was published by the DRTF. The Scottish Executive consulted with interested parties and published its response to the report in January 2001 (Scottish Executive, 2001a). The Executive restricted its response to areas that are devolved to the Scottish Parliament, and the following section covers some of the points relating to Local Government, Health and Social Services:

- Best value: Statutory performance indicators are being adapted to take account of Best Value principles relating to disability
- Participation: The Renewing Local Democracy working group has recommended that steps should be taken to ensure that disabled people are able to participate in local councils and public meetings
- Implementation of DDA: The Scottish Executive will take steps to ensure that the DoH and the DRC work together on the implementation and monitoring of the DDA in the NHS and Social Services
- Equality and inclusion: The Scottish Executive will work with the DRC to promote human rights
- Staff training and awareness raising: A good practice guide to support the implementation of Section 21 of the DDA, which requires reasonable adjustments be made to allow disabled people access to goods and services, was drawn up in consultation with various disability groups and issued to the National Health Service in Scotland (NHSiS) in 1999. Issues raised included equity of access, the role played by Local Health Care Co-operatives
- Mental health: Work relating to mental health including a review of mental health legislation has been undertaken and will be covered later in this section
- Joint working: The Beattie Committee and the Learning Disability Review both recommended an increase in joint working and the promotion of flexible services to promote inclusion
- The Joint Future Group has been looking at ways of improving community care.

Community Care Policy
The Community Care Action Plan, Modernising Community Care (Scottish Office, 1998c) set out the way forward for improved delivery of services for older people, people with physical and learning disabilities, and mental ill-health living in the community. The document drew attention to the main organisations responsible for providing community care, i.e. local authorities, including social work and housing departments, health boards
and NHS Trusts, and Scottish Homes, and asserted that effective community care depended on the ability of these organisations to work together. The importance of joint working was reiterated throughout the document, the message being that social work, health, and housing organisations should work together to review the support needs of their local communities in order to provide more suitable and flexible services. Anticipated changes included:

- A shift towards home care services
- Better and more flexible home care services supported by suitable housing
- More flexible respite services and training to support carers
- Community-based health services to support the shift to home or community-based care
- More cost-effective services

**Direct payments**

The delivery of social services targeted on the individual’s needs is seen as a critical element in the modern welfare state described in the document *Aiming for Excellence Modernising Social Work Services* (Scottish Executive, 1999e). Implementation of the Community Care (Direct Payments) Act 1996 in April 1997 enabled local authorities in Scotland, England and Wales to make cash payments to service users under the age of 65 with physical and sensory impairments, learning difficulties and mental health problems. Inclusion of persons over the age of 65 was later set out in the Scottish Executive Circular (No. CCD4/2000) (Scottish Executive, 2000e) and came into force the following month. Scottish Office guidance for recipients defines a direct payment as, ‘a payment made by a local authority to an individual whom it has assessed as needing community care services’ adding that, ‘the local authority makes the payment instead of arranging the services it has assessed the person as needing’ (Scottish Office, Social Work Services Group, 1997a).

Direct payments give users control over money spent on meeting their community care needs rather than receiving services arranged for them by their local authority. Indeed, the issue of control was a key focus of the disability movement in their campaign to secure direct payments. Previously, English local authorities could only facilitate a cash payment to users through a third party, usually a well-established voluntary sector organisation (Means and Smith, 1998, p. 60). The position differed slightly in Scotland where, through the Social Work (Scotland) Act 1968, local authorities were able to give cash to ‘...any person aged 18 years or over who is in need,
within the meaning of the Act and requiring assistance in exceptional circumstances constituting an emergency, and where to do so would be more cost effective’ (Section 12, Social Work (Scotland) Act 1968). However, knowledge of this ruling amongst social work service personal was limited and no cases have been identified where it was applied (Pearson, 2000, p. 460).

The *enabling* feature of the 1996 Act allows local authorities to choose whether direct payments are adopted or not. For users, such discretion means that receiving a direct payment is ultimately determined by local policy and *not* individual choice. This has resulted in a stark difference among localities - notably between the south of England and Scotland. For example, many local authorities in Scotland (and the North of England - see Zarb et al, 1997) have viewed the policy with suspicion and as a means to erode further public sector provision of services (Pearson, 2000, p. 463). Research on the implementation of Direct Payments policy in Scotland conducted by Witcher et al (2000) is reviewed below.

**POLICY RELATING TO PARTICULAR GROUPS OF DISABLED PEOPLE**

**People with mental health problems**

In Scotland, the Mental Welfare Commission for Scotland has a statutory duty to protect persons who may, by reason of mental disorder be incapable of adequately protecting themselves or their interests, whether they are in hospital, residential accommodation or their own homes. At present 90% of people receiving treatment for mental health problems are admitted on an informal basis. Nevertheless, the implementation of the Human Rights Act 1998 and the DDA 1995 have been instrumental in raising awareness of the complexities of dealing with mental health problems, and in some instances incapacity.

The introduction of the Scottish Parliament created an environment in which increased attention could focus on mental health and related legislation. Mental health law in Scotland had not been reviewed for many years, and in 1999 the Millan Committee was set up with a remit to undertake a comprehensive review of the Mental Health (Scotland) Act 1984, and make recommendations (Scottish Executive, 2000i). Following the publication of the Millan Report, the Executive will allow a period for consideration and debate with a view to launching a Bill in late 2001/2002. However, at present the Adults with Incapacity (Scotland) Act 2000 has replaced parts of the 1984 Act which relate to guardianship and management of patients’ funds. This Act will in due course be consolidated with the new Mental Health Act
into a single Act. See below for further discussion of the terms of the Adults with Incapacity (Scotland) Act, 2000.

The Millan Committee accepted that mental health legislation is primarily needed to cover circumstances in which compulsory measures of care and treatment are necessary. However it was also concerned with aftercare, local authority services, and protection. The Committee recommended that the Mental Health Act should contain a Statement of Principles in order to ensure that the Act would apply equally to people with particular needs including members of minority ethnic communities and disabled children and adults. It was proposed that interventions under the Act and guidance in the Code of Practice should take account of the following principles: non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least restrictive alternative, benefit, and child welfare.

The Committee recommended that the general term ‘mental disorder’ be divided into three categories:

- Mental illness
- Learning disability
- Personality disorder

The Millan Committee recommended that the Mental Welfare Commission for Scotland should continue to provide a protective function for people with mental disorders, take responsibility for the promotion of the principles of the new Mental Health Act, and monitor its operation. It was suggested that the membership of the Commission should be extended to include both service users and carers. Finally, it was recommended that the Commission should collect and publish statistical information relating to mental health.

Mental health is a priority area for both the NHSiS and Local Authorities, who are responsible for community care. Although the Framework for Mental Health Services in Scotland was committed to the idea of local agencies working together, people with mental health problems have been found to experience disadvantages in areas such as housing, social work, health and welfare benefit legislation. It is hoped that the new closer relationship between the Mental Welfare Commission for Scotland and the Scottish Parliament will allow some of these issues to be addressed.

There have been a number of changes in the care of people with mental health problems over the past decade, in particular the move away from long term care towards care in the community. This creates a challenge for service providers who have to deal with considerable numbers of vulnerable
patients who may be geographically dispersed and in touch with a number of agencies. The role of primary care has become increasingly important in the care of people with mental health problems in the community and since 1999; this has been achieved by the bringing together of mental health services and primary care into Primary Care Trusts. Nevertheless, despite the policy to shift care from hospitals into the community, admissions to psychiatric hospitals and units have increased over the past 15 years, albeit it to a smaller number of beds. In the section on statistics, we summarise data on patterns of care for people with mental health problems.

**People with learning disabilities**

The Scottish Executive published the document *The Same as You? A Review of Services for People with Learning Disabilities* in 2000 (Scottish Executive 2000d). The review sought to put in place a common vision for health and social services, focused on a strategy to include people with learning disabilities in mainstream society. The major changes which the review was expected to achieve are summarised below:

- Removal of all but a small number of long-stay hospital places, with specialist healthcare provided in other settings.
- Less formal residential and nursing home care and more supported accommodation and adult placements.
- Much less formal day care and many more day opportunities, provided, for example, in education, leisure and employment.
- A greater range of employment opportunities.
- More children educated in mainstream schools.
- Most people with learning disabilities having access to mainstream health, social care, education and employment services.
- Jointly commissioned services provided for people with complex needs.
- People with learning disabilities having access to independent advocacy when they need it.
- Direct payments available to people who want and can use them.
- A life plan, for every person who wants one.
- Access to independent advocacy and direct payments for people with learning disabilities.
- Greater community participation by people with learning disabilities.
- Measures to reduce bullying and harassment of people with learning disabilities.
- Access to routine screening programmes for people with learning disabilities.

Some areas have taken forward these broad proposals at local level with enthusiasm. For example, in Glasgow City a joint strategy for people with
learning disabilities was published (Glasgow City Learning Disability Partnership, 1999). Principal partners in this strategy were Glasgow City Council, Greater Glasgow Health Board, Scottish Homes and Greater Glasgow Primary Care NHS Trust. With the broad aim of enabling men and women with learning disabilities to live inclusive and meaningful lives in their local communities, the strategy had significant change implications for all partners involved. It was proposed that, instead of each agency keeping control of its own budget, a pooled ring fenced budget for learning disability services should be established with agreed devolution of resources to area based teams for people with additional and complex needs and for service development. Specialist care management teams would be created, consisting of social workers, community nurses and occupational therapists with input from service providers. Specific changes were envisaged for different parts of the health service. Efforts were to be made to ensure access to generic primary health services, the health services should no longer provide long term residential care for people with a learning disability, the role of community learning disability teams should be configured and Lennox Castle, the local long stay hospital, should close. Similar changes were envisaged for housing and social work services. Scottish Homes and Glasgow Housing Services were to play a much greater role in providing houses for people with learning disabilities in community settings and day centres run by social work were to provide back-up for people with learning disabilities and carers in the community, rather than being places where people spent most of their time. The Glasgow strategy envisaged that people with learning disabilities would spend a much greater proportion of their time in mainstream employment and education, and that 500 new jobs for people with learning disabilities in the city would be created by 2003. An employment support unit was set up, funded jointly by Scottish Homes, Glasgow City Council, Greater Glasgow Health Board and Greater Glasgow Primary Care NHS Trust. It was not clear to what extent the Employment Service and the Local Enterprise Company have been involved in this initiative and its success is not yet known.

Whilst an area like Glasgow City has relatively little difficulty in involving key players in such discussions, partnership working is obviously much more difficult for local authorities whose territory cuts across that of several health boards. The implementation of Joint Investment Plans for different groups of disabled people clearly requires research to determine whether these policies are delivered effectively in practice.
The Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act changed the system for safeguarding the welfare and managing the finances and property of adults who lack the capacity to take some or all decisions for themselves because of mental health problems or inability to communicate with others. The Act replaces existing legislation, some of which dates back to the twelfth century, by which an adult with mental health problems or learning disabilities could lose all power to make important life decisions, including those concerning finances and health. It was felt that the status of *incapax* accorded to certain individuals under existing legislation was capable of being abused. The new Adults with Incapacity (Scotland) Act 2000 is intended to benefit the adult with impaired capacity, take account of their wishes, restrict their freedom as little as possible and encourage them to develop existing or new skills. The Act allows other people to make decisions on behalf of these adults, subject to safeguards. Under the Act, the Public Guardian has a supervisory role and keeps registers of attorneys, people who can access an adult’s funds, guardians and intervention orders. Local authorities look after the welfare of adults who ‘lack capacity’ and the Mental Welfare Commission protects the interests of adults who ‘lack capacity’ as a result of mental disorder. Individuals can give another person power of attorney so that if their capacity diminishes in the future some one else may take decisions on their behalf. Individuals, normally relatives or carers, can apply to the Public Guardian to gain access to the funds of an adult incapable of managing those funds. Authorised care establishments can manage a limited amount of funds and property of residents who are unable to do this themselves. The Act allows medical treatment to be given to an adult who is unable to consent. Individuals can apply to the local Sheriff Court for an intervention order to allow them to take a particular course of action on behalf of an adult with incapacity (see discussion of how this power might be used in the context of house purchase, Chapter 5). Individuals may also be granted a guardianship order to allow longer term management of affairs. Some critics (e.g. Ritchie, 2001) maintain that the new legislation does not represent a significant improvement on existing arrangements. Clearly there is a need for close monitoring of the Act’s impact.

**People with sensory impairments**

A report of a national inspection of social work services for people with a sensory impairment was published in 1998 (*Sensing Progress*, SWSI, 1998). Overall, the inspection found that:

- The quality of individual assessment and service provision varies.
• The arrangement for collaboration between specialist and other social work staff is not always clear, particularly in complex cases.
• Some social workers seem reluctant to acquire the basic knowledge and skill necessary to work with people with a sensory impairment but are willing to work alongside specialist staff when required.
• Care managers may lack adequate knowledge of individual service users and therefore may purchase inappropriate services.
• Specialist social workers may be disadvantaged by not always being offered the same training opportunities as their other professional colleagues in respect of child protection and mental health work. They may be less confident in these aspects of practice.

The inspectors looked at the quality of collaboration with health and education, and concluded that the quality of joint working was very variable. This report highlights areas of community care where partnership is less than fully developed, not least because health and social work still have separate inspectorates who focus attention on the input of one particular service delivery agency. As community care develops in the future, there is likely to be a need for joint inspection, as well as joint service delivery.

**People with physical impairments**
As noted earlier, health and social care has tended to adopt an impairment-focused approach to policy for disabled people. The consequence of this is that energy at national level may be focused on one particular group for a period of time (e.g. people with learning disabilities), whilst other groups attract relatively little attention. There has been no recent national review of services for people with physical impairments, although the Scottish Health Advisory Service (SHAS) comments on such services in its regular reviews of the work of health boards.

**Children and Health and Social Care Policy**
The Riddell Report on the Education of Children with Severe Low Incidence Disabilities emphasised the importance of including disabled children in mainstream schools and highlighted the need for effective inter-agency working between education, social work and health and between public and voluntary sectors. Barriers to inclusion relating to health and social care services were noted. It was suggested that pooled funding arrangements were likely to be an effective way of meeting the health, education and care needs of children and young people with the highest support needs. Attention was drawn to problems with the provision of therapy services. Whilst education authorities hold budgets to purchase therapy services for children with SEN, therapists are employed by health, leading to disputes over working prac-
tices and management arrangements. Parents of children with SEN complain frequently that the provision of therapy services is woefully inadequate. In addition, it was acknowledged that an ongoing barrier to inclusion was the uncertainty about responsibility for the administration of medication to children. Teachers were told that they could administer medicine on a voluntary basis, but there were doubts as to whether they were covered by professional indemnity arrangements. As a result, teachers and auxiliary staff were reluctant to take on this work and children were being refused a place in mainstream school. The Committee felt that such uncertainties should be resolved as soon as possible, but at the time of writing the issue of professional indemnity has not been satisfactorily resolved.

The care of children in hospital remains a key area of concern. In 1993, the Scottish Office issued guidance on the care of children in hospital. It stated that:

- Children should only go into hospital if the care they need cannot be provided at home or on a day-care basis.
- Children should be discharged ‘as soon as socially and clinically appropriate’.
- Children have a right to information appropriate to their age, understanding and circumstances.

The Standards in Scotland’s Schools (etc) Act 2000 placed a duty on local authorities to provide education for children in hospital. As noted in Chapter 2, Children’s Services Plans are the principal vehicle for working out joint strategies between social work, health and education. Initially these plans were orchestrated by social work with a relatively small input from health, education and the voluntary sector. In the future it is hoped that these plans will be genuinely joint ventures.

**OFFICIAL STATISTICS: HEALTH**

In this section, we consider the nature of health statistics and what they tell us about the prevalence of disabling conditions in Scotland. Figures relating to health and NHS use are gathered in a variety of ways. The Information and Statistics Division (ISD), Common Services Agency for the NHSiS, is responsible for the majority of data collection and presentation. Technological advances have enabled statisticians to link a range of data sets e.g. general practice data provided by the Continuous Morbidity Recording (CMR), mortality data (SMR) provided by the Registrar General,
and hospital in-patient data provided by the SMR01 scheme. Whereas data relating to hospital inpatients and death have been available for some years, the addition of CMR data is a significant step forward. Information is also available on face-to-face contact between a GP and patients and data will soon be available on contacts between patients and practice nurses, health visitors, and district nurses. Whereas data on illness is growing in quantity and complexity, there has so far been little development of knowledge and information about the health of disabled people and their access to preventative as well as acute medical services.

By European and UK standards, Scotland’s health record is poor, and within Scotland there are marked and growing inequalities between the health of richer and poorer communities. (1999 *Health in Scotland*, Scottish Executive, 2000). The 1991 census showed that 12.9% of all residents reported a limiting long-term illness. However, regional differences are apparent with the figure rising to over 20.0% in some of the more deprived areas. Following the publication of the Black Report (1982) and the Acheson Report (1998), it has been accepted that a relationship exists between socio-economic inequalities, disability, and health including chronic illness. People living in deprived areas have a higher level of exposure to factors that may have a negative effect on their health, and although life expectancy has increased considerably the gap between the most at least affluent has widened in the last twenty years. Measurements of deprivation have been criticised on a number of levels, and no ‘ideal’ index is available.

In Scotland the most frequently used measure of deprivation is the Carstairs index which is based on a combination of overcrowding, male unemployment, low social class, and car ownership. The population is normally distributed across seven categories which are ordered from 1, least deprived, to 7, most deprived. However, levels of deprivation are not evenly distributed across the 15 Health Boards, and some have a far higher proportion of their population living in categories 6 and 7 than others. These include Greater Glasgow Health Board where over half (51%) of the population live in deprivation categories 6 or 7, and Argyll and Clyde and Lanarkshire, where a quarter live in the two most deprived categories.

As we noted above, illness and disability are not synonymous. Nonetheless, people who are seriously ill are likely to be disabled and therefore information relating to the social creation of disability may be gleaned from health statistics. In the following paragraphs, we first explore mortality rates across Scotland. Subsequently, we look at the social characteristics of people who experience two particular types of illness, stroke and mental
health problems. These two categories of illness are significant because they are both associated with social disadvantage and are likely to lead to longer term impairments.

The following chart shows standardised mortality ratios for different authorities; the rate for Scotland as a whole is 100 with higher ratios representing a higher death rate. It can be seen that the three health boards with highest proportion of residents living in deprivation categories 6 and 7 also have the highest death rates.

*Figure 4.1: Standardised mortality ratio for selected causes by administrative area, Scotland.*

Source: 1999 *Health in Scotland*

Higher mortality rates are a crude measure of overall health and disability - for people with chronic conditions death may signify the end of many years of restricted activity.

ISD has a web site which provides an overview of inequalities in health with respect to material deprivation, *Deprivation and Health in Scotland*. These data will provide the basis for identifying and tackling inequalities. The data show that there is a higher incidence of, and mortality from, heart disease and stroke amongst people of working age living in deprived areas. Amongst people over 65 there is no association in the incidence associated with level of deprivation. However, there is a tendency for people living in *less* deprived areas to have an angiography and coronary artery bypass following a first heart attack sooner than those living in *more* deprived areas. Mental health problems are also more prevalent amongst people living in deprived
areas. Hospital data show higher rates for depression, anxiety and schizophrenia. However, data relating to whether or not there are inequalities in level of treatment are not currently available. The figures relating to cancer are more complex, with the incidence of lung and cervical cancer being higher amongst those living in deprived areas. There is an inverse relationship with breast cancer, lower rates being associated with higher incidence of deprivation. Nevertheless, amongst the four most common cancers, lung, cervical, breast, and bowel, there is decreasing survival with increasing deprivation. Accident risk has also been found to be related to deprivation, although there are also differences in the types of accidents associated with different age groups. A final measure of health and ‘fitness’ worthy of mention here, is lung function. Tests are routinely applied in the assessment of health amongst the general population; figures from the Scottish Health Survey 1998 (Scottish Executive Health Department, 2000) show that adults in Greater Glasgow, an area of high deprivation, had the lowest mean values in the country.

**Stroke: an example of current statistical data**

In this section we focus briefly on the figures available for stroke which, as mentioned earlier, is the single largest cause of severe disability in the UK. An ISD Scotland National Statistics publication presents data relating to stroke derived from three sources, deaths provided by the Registrar General for Scotland, hospital inpatient data and GP data.

*Figure 4.2: Number of patients admitted to hospital with a principal diagnosis of stroke by gender and year*

(Source: ISD)
The above figure shows that the number of patients admitted to hospital with a principal diagnosis of stroke has risen from 10,864 in 1989 to 12,945 in 1998. However, this does not necessarily indicate that there has been a significant rise in the number of strokes; it is possible that some of the increase could be accounted for by a combination of a rise in the number of people admitted to hospital rather than being cared for at home, and improvements in diagnosis. Furthermore, although the number of people admitted to hospital has risen over the time period, the mortality rate has fallen. An increasing number of males and females aged 45-64 who have a stroke now survive. These data have significant implications in terms of rehabilitation services, job retention, housing, and community care.

It is important to bear in mind that although figures derived from ISD show that there is no relationship between deprivation category (see above for definition) and death from stroke amongst older people, amongst people under 65 the mortality rate increases with level of deprivation.

**Figure 4.3: Stroke: standardised mortality ratios (SMR) by deprivation category and age group (1994-98)**

![Bar chart showing standardised mortality ratios by deprivation category and age group (1994-98)]

Source: ISD

Because the incidence of stroke increases with age (81% of admissions in Scotland in 1997/98 were aged 60+), service provision is often geared towards older adults. People who have a stroke experience a sudden onset of disability; about half are left with a permanent impairment and, whereas recovery may be rapid initially, the process can continue slowly over many years, requiring support from a number of services. Despite the recent shift
away from hospital care towards community-based provision, the majority of stroke rehabilitation is still carried out in a hospital setting (Bugge and Alexander, 1998). A survey of patients following discharge from hospital in England found a lack of co-ordination at the hospital/community interface, under-referral to support services, inadequate review of progress, furthermore, none of the participants had had paid work since their stroke (Kelson, et al, 1998). Although, this study only covered England, Wales, and Northern Ireland, and was not specifically designed to include younger stroke survivors, there is no reason to suppose that the situation is any better in Scotland.

The following chart shows the incidence of strokes per thousand in the 45-64 year age group by health board in 1997-98. It can be seen that again the authorities with the highest proportion of residents living in deprived areas have the highest incidence, i.e. Greater Glasgow, Argyll and Clyde, and Lanarkshire. Inspection of the chart reveals that Ayrshire and Arran also have a relatively high incidence of stroke amongst residents ages 45-64.

*Figure 4.4: Incidence of stroke in the 45-64 age group (patients) by health board (1997-98)*

The combination of data presented above paints a clear picture of the number and location of people living in Scottish communities who have survived a stroke. The data show that stroke is more prevalent amongst
people of working age who live in deprived areas. It would therefore be of interest to know if there is equality of access to physiotherapy, occupational therapy, speech therapy, and disability employment advisors in the longer term, or if there is a similar pattern to that noted in the access to angiography and bypass for people with heart disease. Unfortunately these figures are not readily available.

The section relating to stroke has been included primarily as an example of the relationship between illness, disability and social deprivation. As mentioned earlier similar figures are available from ISD covering heart disease, cancer, mental health, learning disabilities, and accidents (both children and adults). The Scottish Health Survey also publishes figures relating to these areas.

OFFICIAL STATISTICS: COMMUNITY CARE

In recent years there have been substantial changes in the way community care services are provided. The move to enable people to live in the community, with support where required, together with an increased emphasis on commissioning services from private and voluntary agencies, and a growing private sector make the compilation of statistics problematic. Scottish Community Care Statistics 1999 (Scottish Executive, 2000k) is the first in what will be a series of publications presenting statistics on community care. It brings together information from the fields of health, social work, and housing in order to present a complete picture of service provision for adults in Scotland. Initially data collected by SEHD Community Care Statistics Branch will be released in the form of short statistical releases, or information notes, in order to allow access to the data as soon as possible. The compilation of these interim publications together with further analysis and interpretation will then be published as one complete document. The Executive recognises that as the means of service provision has changed so too have the type of data required to monitor it. In order to address these issues work is underway within the Social Work Information Review Group (SWIRG) to change the way in which social work data are collected. However, until this system is established current information relies on the availability of relevant data.

Scottish Community Care Statistics 1999 (Scottish Executive, 2000k) is divided into seven main sections presenting figures relating to older people, adults with learning disabilities, adults with mental health problems, physically disabled adults, other client groups, carers and expenditure on community care. Each section is then subdivided into a number of areas
including the balance of care, domiciliary care, NHS community health services, day care, special needs housing, residential care homes, private nursing homes and hospitals.

The interim publications present data on one specific area as they become available, e.g. *Home Care Services Scotland 1999* (Scottish Executive, 2000h) presents data derived from returns made by local authorities covering home care services provided or purchased by local authorities. These data show that, in the week ending 26th March 1999, 74,058 clients received 375,300 hours of home care. Eighty-five percent of the clients were over retirement age (65+), three-quarters (76%) had physical disabilities. Three quarters of clients lived alone, 9% lived in households with two or more clients. Almost four out of five clients (79%) only received services on weekdays, mostly between 7 a.m. and 2 p.m. Eighty-six percent of the home care was provided exclusively by the local authority, 8% was provided by the private/voluntary sector, and 6% was provided by a combination of local authority and private/voluntary sector. Attention was drawn to the fact the there is evidence to suggest that an increasing amount of home care services are provided without local authority involvement; to date statistical information is not available. Of the 15% of clients who were aged less than 65, almost half (48%) had physical disabilities, 11% had mental health problems, 12% had learning difficulties.

**Community care statistics relating to people with mental health problems**

As with physical illness there are a variety of mental disorders which range in severity and the extent to which they are likely to have *substantial and long-term adverse effects on an individual’s ability to carry out normal day-to-day activities*. Surveys of self-reported illness suggest that approximately one in four adults experience some level of mental health problems, and illness severe enough to require professional assistance (SEHD 1999).

Mental disorders affect people in all age groups, however, some sectors of society experience higher levels of certain disorders. Poor mental health is known to be associated with deprivation. The following chart shows the rate of GP contacts per 1,000 by deprivation category in Scotland, for the year ending March 2000. Inspection of the figures presented in Figure 4.5 show a clear relationship between deprivation and mental health problems, consultation rates increasing with increasing levels of deprivation.
Estimates based on Continuous Morbidity Recording indicate that a mental health diagnosis was recorded by approximately 10% of all GP/patient consultations in 1998. For most age groups the workload for GPs and prevalence rates associated with anxiety and depression are markedly higher for females than males, particularly in the middle years 25-44. The rising number of older people with the concomitant increase of dementia creates a challenge for health services. People with mental health problems come into contact with the health service when attending their GP, outpatient appointments, day care, residential care and hospital inpatients.

*Figure 4.5: Mental Health: GP contacts (rate per 1,000 population) by deprivation category in Scotland, year ending March 2000.*

![Graph](image)

*Source: ISD*

Note: Deprivation categories 1-7 are based on the Carstairs index - see above for explanation

Table 4.1 shows the number of day centres for people with mental health problems, the number of places, and people attending 1985-1998. It is important to bear in mind that the first three columns cover a decade, whereas the later figures are presented annually. It can be seen that overall there has been a considerable increase in the number of day places available and thus the numbers attending. However, these figures give no information about demand for places or the suitability of current provision.
Table 4.1: Number of day centres for people with mental health problems, number of places, and people attending 1985-1998.

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<td>722</td>
<td>963</td>
<td>815</td>
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</tbody>
</table>

Source: Scottish Community Care Statistics 1999

Only nine authorities reported having day centre provision primarily for people with mental health problems, Angus, Dundee City, City of Edinburgh, Eileanan Siar, Highland, Inverclyde, Midlothian, North Lanarkshire, Perth and Kinross. Between them these authorities reported having 17 day centres for people with mental health problems, providing 467 places, with a total of 815 people attending. The number of places per 10,000 population aged 16-64 and the number attending bear little relationship, and it would be of interest to know how many hours clients are able to attend.

Table 4.2 shows the number of residential care homes primarily intended for people with mental health problems, the number of beds available, and number of residents.

Table 4.2: Number of local authority, private, and voluntary residential care homes for people with mental health problems, number of beds, and number of residents 1985-1999.

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</tr>
<tr>
<td>Total</td>
<td>238</td>
<td>442</td>
<td>1,105</td>
<td>1,223</td>
<td>1,252</td>
<td>1,300</td>
<td>1,439</td>
</tr>
<tr>
<td>No of residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA</td>
<td>129</td>
<td>96</td>
<td>40</td>
<td>33</td>
<td>25</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Private</td>
<td>-</td>
<td>33</td>
<td>71</td>
<td>109</td>
<td>112</td>
<td>114</td>
<td>121</td>
</tr>
<tr>
<td>Voluntary</td>
<td>39</td>
<td>246</td>
<td>862</td>
<td>915</td>
<td>944</td>
<td>1,009</td>
<td>1,115</td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td>375</td>
<td>973</td>
<td>1,057</td>
<td>1,081</td>
<td>1,138</td>
<td>1,254</td>
</tr>
</tbody>
</table>

Source: Scottish Community Care Statistics 1999
Inspection of the above table reveals that the number of residential homes for people with mental health problems has increased from 34 in 1985 to 194 in 1999. Over this time the number of beds has increased from 238 to 1,439, and the number of residents from 168 to 1,254. However, the main change has been the shift from local authority to a mixture of private and voluntary sector providers. In 1999 89% of residents were in voluntary run homes, 10% in private homes, and only 1% in homes run by the local authority. This is not surprising as figures show that the average weekly charge per resident in local authority residential care is £690, compared to £348 in private care, and £264 in the voluntary sector. Again figures show that there is a marked variation in the number of residential places between different areas, with East Ayrshire, East Renfrewshire, the Orkney and Shetland Islands having no residential provision for this client group.

Admission and discharge figures for local authority, private, and voluntary residential care for people with mental health problems, 1985-1999, show that whereas in the past the majority of admissions were long stay, in 1999 60% of all admissions and 62% of discharges were short stay. However, this pattern only applies to the voluntary sector; in the local authority and private sectors a higher proportion of admissions and discharges are still long-stay.

Data relating to the age of long stay residents with mental health problems reveal that in 1999, 14% were aged 16-30 years, 29% were 31-45 years, 43% were 46-64 years, and 14% were 65+. These figures reflect a fall in the younger age group from a high of 22% in 1990 to 14% in 1999, and a slight rise in the 46-64 age group from a low of 37% in 1990 to 43% in 1999. However, if we look at the following chart which shows actual numbers, we can see that the number of long stay residents with mental health problems has risen from 168 in 1985 to 1,250 in 1999. Between 1990 and 1998 the largest proportion of residents (about one-third) stayed for between 1 and 3 years. Around a quarter of discharges (25%) went to their own homes, another quarter (25%) were transferred to another home, 16% entered hospital.
The last figures to be presented in this section relates to hospitals. The following table shows the average occupied beds and the mean stay in days. These figures include mental illness, psychogeriatrics, child and adolescent psychiatry. It can be seen that the bed availability, occupancy, and mean stay have all decreased since the 1980; however, the throughput (based on average inpatient discharges/average available staffed beds per year) has increased. Thus psychiatric hospitals are following a similar trend to other specialities in that a higher number of patients are being treated per bed.

**Table 4.3: Bed availability and psychiatric speciality 1985-1999.**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Average available beds</td>
<td>16,463</td>
<td>14,407</td>
<td>11,034</td>
<td>10,392</td>
<td>9,580</td>
<td>9,076</td>
<td>8,674</td>
</tr>
<tr>
<td>Average occupied beds</td>
<td>14,118</td>
<td>12,634</td>
<td>9,754</td>
<td>9,084</td>
<td>8,358</td>
<td>7,891</td>
<td>7,358</td>
</tr>
<tr>
<td>Mean stay (days)</td>
<td>182.5</td>
<td>152.5</td>
<td>107.6</td>
<td>98.1</td>
<td>90.8</td>
<td>85.5</td>
<td>83.5</td>
</tr>
<tr>
<td>Throughput</td>
<td>1.5</td>
<td>1.7</td>
<td>2.1</td>
<td>3.0</td>
<td>3.3</td>
<td>3.5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

*Source: ISD cited in Scottish Community Care Statistics 1999*

The final table presented in this section shows the age breakdown of patients in mental illness hospitals and psychiatric units at 31st March 1985-1999. It can be seen that the number of people with mental health problems in hospitals has declined until 1995 after which it remained...
relatively stable. There has been a slight increase in the proportion of people aged less than 65 and over 85, whereas the proportion of people aged 65-84 has decreased. Overall 41% of people in hospital with mental health problems were aged less that 65.

**Table 4.4: Age breakdown of patients in mental illness hospitals and psychiatric units at 31st March 1985-1999**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>&lt;65</td>
<td>5,464</td>
<td>4,418</td>
<td>3,380</td>
<td>3,352</td>
<td>3,807</td>
<td>4,041</td>
<td>4,059</td>
</tr>
<tr>
<td>65-74</td>
<td>2,808</td>
<td>2,365</td>
<td>1,714</td>
<td>1,584</td>
<td>1,433</td>
<td>1,488</td>
<td>1,389</td>
</tr>
<tr>
<td>75-84</td>
<td>3,866</td>
<td>3,658</td>
<td>2,381</td>
<td>2,214</td>
<td>2,198</td>
<td>2,081</td>
<td>1,936</td>
</tr>
<tr>
<td>85+</td>
<td>1,697</td>
<td>2,028</td>
<td>1,612</td>
<td>1,447</td>
<td>1,372</td>
<td>1,388</td>
<td>1,322</td>
</tr>
</tbody>
</table>

*Source: ISD cited in Scottish Community Care Statistics 1999*

As with the data presented relating to stroke, the figures relating to mental health problems have been presented as an exemplar of the type of community care statistics that are available. They suggest that fewer people with mental health problems are being looked after in hospitals and more day care places are available. At the same time, they indicate a very significant increase in the number of residential care homes, beds and residents. There is also a shift to residential care provided in voluntary and private sector accommodation which is cheaper than local authority provision. Questions are therefore raised about the implementation of community care policies; there is clearly a danger that long-stay hospitals have been replaced by other forms of institutional rather than community-based provision. Scottish Community Care statistics publish equivalent data on older people, adults with learning disabilities, physically disabled adults, and carers and these figures raise additional questions about the direction of community care policies.

**REVIEW OF RESEARCH**

The Chief Scientist’s Office funds a considerable amount of work on health outcomes of particular interventions, but there is a far smaller literature on disabled people’s experiences of health and social services. Some examples of the latter type of research are provided below.

**Overviews of health and social services for disabled people**

An overview of health and social work services for disabled people was conducted by Stalker and Reddish for the Scottish Office in 1996. The following key findings emerged:
• Support to disabled people is dominated by segregated services, in which individuals are cast into the role of dependent and subject to assessment, rationing procedures and restricted choice. They are seen as having ‘needs’ rather than entitlements.
• Services to disabled people are accorded a relatively low priority and often lack the underpinning of a clear strategy.
• There is considerable territorial injustice, both within and between regions.
• Inter-agency collaboration between health boards, social work departments and the voluntary sector appears good, but housing needs to be brought into the fold (N.B. this positive view of inter-agency working has not been endorsed by other research and policy reviews).
• There is insufficient flexibility in service delivery, sometimes for financial reasons.
• Some policies tend to pull in different directions, e.g. charging for short-term care has created a ‘perverse incentive’ to use hospital beds; decreasing numbers of old people entering care have led to some independent sector homes ‘targeting’ disabled people.

Recommendations include the development of corporate strategies by local authorities based on reliable estimates of number and needs, the development of a national strategy backed up by a Disability Unit and a new focus on user participation in determining the nature of services.

Curtice and Ross (1997) undertook research to assess the potential for bringing health promotion and community care closer together, gathering the views of users, carers and service providers. Service users felt that rather than being health-promoting, the provision available to them often promoted ill health by reinforcing social segregation and low self esteem. Carers, whilst sometimes willingly adopting this role, also felt trapped with limited opportunities for their own development. Telephone interviews with purchasers and providers of community care services suggested that:
• Community care was seen as a social work responsibility, with education and transport insufficiently involved.
• Quality of life was on the agenda in strategies for people with learning disabilities, drug and alcohol problems.
• There was a demand for joint training between health and social care professionals to resolve boundary disputes.

Direct Payments
In Scotland at the time of writing only 13 out of the 32 authorities in Scotland have either fully operational or pilot direct payment schemes with current
users. The total number of users across these projects amounts to 143 (Witcher, Stalker, Roadburg and Jones, 2000, p. ii), which indicated that three years after implementation, considerable confusion still remained amongst local authorities as to what direct payments were and how they might operate. To date, Witcher et al’s study is the most comprehensive account of direct payments in Scotland and provides a detailed focus on the effectiveness of current arrangements for the policy across Scotland, barriers to wider implementation and methods of tackling them (Witcher et al, 2000, p. i). Despite low use of the scheme, existing users in Scotland have reported high levels of satisfaction with direct payments (Pearson, 2000, p. 470; Witcher et al, 2000, p. iii).

There continue to be inequalities between different groups of disabled people in accessing direct payments. Witcher et al (2000) reported that 87% of Scottish users - or a total of 125 - had physical or sensory impairments. Only 12 per cent - 17 users - had learning difficulties and one person had Asperger’s Syndrome. No one using mental health services was receiving a direct payment (Witcher et al, 2000, p. 68). Although this imbalance broadly mirrors the overall pattern in England and Wales (see Holman and Bewley, 1999 for learning difficulties and Maglajlic, Bryant, Brandon and Given, 1998 for mental health), in Scotland the low take-up of persons with learning difficulties and exclusion of mental health users in local schemes is particularly apparent. Furthermore, no persons from minority ethnic communities received a direct payment at the time of Witcher et al’s research.

Despite limited use of direct payments for persons with learning difficulties, where access has been allowed, again, a favourable response has been given by users (see Pearson, 2000, p. 471-472). As Witcher et al (2000, p. 14) report, restricting access largely to direct payments users with physical and sensory impairments has reflected widespread local authority confusion over how to interpret the requirement that an individual ‘must be willing and able to manage a direct payment’ (Scottish Office, 1997a, p. 12). In a bid to expand user access to direct payments, this clause is currently receiving attention in the redrafting of the original 1997 guidance (this is detailed in the wider context of reform in the next section).

A further barrier to direct payment implementation in Scotland identified in the research relates to the level of understanding and, in turn, promotion of policy by social work staff (Witcher et al, 2000, p. 69-74). As mentioned previously, this has drawn on a number of issues including staff fears about job losses through the use of a policy as a means of privatising public sector
services (see also Pearson, 2000, p. 466) or simply changes in social work roles. Similarly, the importance of the role of supporting organisations in the positive promotion of policy has been identified (Witcher et al, 2000, p. 74-45), yet remains inconsistent and often limited throughout the country. The type of support needed is likely to include help with administering PAYE schemes and training personal assistants. Organisations such as the Glasgow Centre for Independent Living provide support in urban areas, but in rural areas such support is thin on the ground.

Health and social care provision for disabled children and young people

Closs (1998) undertook a small scale study of six young people with serious medical conditions. Based on in-depth interviews, the research explored the extent to which young people with significant medical conditions felt they were able to achieve adult status. The young people felt that even though they were still sometimes dependent on parents for medical interventions, they felt they were ‘mentally’ adults because they took responsibility for their own decision making.

A less positive view is presented of the transition to adulthood by Baron et al (1999) on experiences of the Learning Society by adults with learning difficulties. This research documents the way in which services provided by social work, health, education, employment and the benefits agency all conspired to restrict opportunities of people with learning difficulties to develop as adults with both independence and inter-dependence.

ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES

Following the election of the Labour Government to Westminster in 1997 and the establishment of the Scottish Executive in 1999, a considerable number of consultation and policy documents have been published in the fields of health and social care. The pace at which initiatives have been launched, in conjunction with the blurring of boundaries between different agencies as the move towards joint working progresses, can make it difficult to ascertain the current position. There is inevitably a time lag before accurate statistical data are available, and many plans are still in their infancy.

When considering future health policy in relation to disabled people, three recent publications are of particular significance, *Our National Health: A plan for action, a plan for change* (Scottish Executive, 2001b) the Report of the
Joint Future Group (Scottish Executive, 2000j) and the Scottish Executive’s response to the recommendations of the Joint Future Group (Scottish Executive, 2001c).

Our National Health: A plan for action, a plan for change sets out a programme of investment and reform designed to:

- Improve Scotland’s health, and close the health gap between rich and poor.
- Restore the NHS as a national service - ensuring equality of care across Scotland.
- Improve access to services in terms of waiting times, and ease of access.
- Give service users a real voice in the way the NHS is run.
- Provide better care for the young, and older people.
- Tackle the main priorities, heart disease, cancer, and poor mental health.
- Improve care and standards in the NHS by valuing and empowering staff, and improving working practice.

Following the launch of Our National Health: A plan for action, a plan for change (Scottish Executive, 2001b) the Scottish Executive responded to the recommendations of the Joint Future Group, whose role is to build on existing structures in order to secure better outcomes for people who use services. The Scottish Executive accepted a large proportion of the Joint Future Group’s recommendations, which hinge on the blurring of boundaries between health and social care in planning, resourcing and delivering care. Joint assessments and sharing of statistical information are also key elements.

As noted above, direct payments have been seen as an important element within the modern welfare state, allowing services to be delivered in a flexible way to meet users’ needs and without an elaborate infra-structure. Since the implementation of direct payments in 1997 a number of changes have been made to the original policy framework.

Following the election of New Labour in May 1997, a push to extend direct payments to a wider user population has emerged. Whilst the enabling framework for the legislation remains in place, the advent of the Scottish Parliament and its new devolved responsibilities for social services has accentuated differences between policy change north and south of the border. The main difference centres on the pace of change between England/Wales and Scotland, with Scottish legislation at least six months behind.
In England and Wales, the removal of the upper age limit of 65 was announced in the White Paper *Modernising Social Services* (DoH, 1998). This was followed by publication of new direct payment policy and practice guidance (Department of Health, 1999), replacing the original framework (Department of Health, 1997). Although some changes and modifications to earlier guidance were made, the basic framework remains unaltered. However, a clear emphasis has been given to extending policy to a far wider user population (Department of Health, 1999, para. 2). Under the terms of the Carers and Disabled Children Act 2000, parents or guardians who look after disabled children will be entitled to a direct payment, allowing them to decide what services to buy for their children. The Act also introduces a statutory duty on local authorities to provide services directly to informal carers to meet their assessed needs (as determined by the 1995 Carers (Recognition and Services) Act. In turn, local authorities will be given the opportunity to offer direct payments as part of this support package. Finally, 16 and 17 year olds will be able to access direct payments.

Reform of the Scottish guidance has yet to emerge, although as mentioned earlier, brief changes extending payments to older people have been made through a Scottish Executive Circular (Circular No. CCD4/2000, Scottish Executive 2000e). By delaying change, Scottish Executive planners have decided to allow time to focus more specifically on the areas requiring change (personal communication). This is said to acknowledge some of the broader difficulties in implementing policy per se and those specific to Scotland. As part of this process, a series of seminars have been organised, inviting local authority planners, users, disability organisations and other interested parties to participate and identify issues of concern.

However, pressure to widen access for some user groups has emerged in other policy documents, in particular, the Review of Services for People with Learning Disabilities acknowledged that ‘direct payments could play a far bigger role in the future’ (Scottish Executive, 2000d, para. 40). The view of the Scottish Executive is that ‘by 2003, any one who wants a direct payment should be able to have them’ (Scottish Executive, 2000d, p. 24). Similarly, groups such as Values into Action have been active in promoting direct payments for this group through their conferences and campaigning. Also in light of the absence of mental health direct payment users documented in Witcher *et al*’s study, research is currently being commissioned by the Scottish Executive’s Central Research Unit to examine the reasons behind this.

Overall, it is clear that health and social care policy is committed to social
inclusion of disabled people, inter-agency working, the delivery of flexible, person-centred services, access to preventative as well as acute medicine and the implementation of the DDA in relation to employees and service users. The extent to which such principles are being implemented in practice remains to be seen. In addition, aspects of the wider health and social agenda which have a particular impact on disabled people require attention. These include the impact of genetic screening programmes and new reproductive technologies.

**Future research is needed to address the following questions:**

- How effectively are community-based health and social care services being developed in different parts of the country for particular groups of disabled people (e.g. people with mental health problems, people with learning disabilities)? Do disabled people have equal access to preventative as well as acute medicine?
- To what extent do statistics on particular illnesses or impairments (e.g. stroke, mental health problems) indicate the availability and experience of services? Do they allow the quality of services to be monitored over time?
- As direct payment policies become better established, what is their longer term impact on particular groups of disabled people in different geographical locations?
- Following its implementation, what is the impact of the Adults with Incapacity (Scotland) Act 2000?
- How are health services experienced by different groups of disabled people in relation to gender, age, geographical location, ‘race’ and social class?
- What is the impact on disabled people of genetic screening programmes and new reproductive technologies?
- How effective are joint working arrangements between health, social work, housing and economic regeneration agencies in relation to policy and provision for disabled people?
- How effective is inter-agency working in relation to the provision of services for disabled children? What progress is being made to put joint funding packages in place for children with the most significant difficulties? How effective is health provision in schools, particularly in relation to the administration of medicines, which may have a major impact on inclusion policies?
- To what extent is effective educational provision being made for children with progressive conditions who may have to spend a significant amount of time in hospital?
INTRODUCTION

In this section we first make some general comments about the nature of housing tenure in Scotland compared with England and Wales and the housing status of disabled people compared with non-disabled people. Subsequently, we review current housing policy as it affects disabled people. This is followed by a discussion of the official statistics which are available in relation to disabled people in Scotland. Finally, we consider the nature of the research evidence which is currently available in relation to the housing position of disabled adults and children in Scotland and consider current gaps in knowledge and fruitful avenues for future research. It is worth noting that although responsibility for housing is devolved to the Scottish Parliament, responsibility for taxation, the regulation of financial institutions and social security all remain at Westminster. The potential for the development of diverse Scottish housing policy in relation to disabled people is clearly affected by these constraints.

CURRENT POLICY

In understanding housing provision for disabled people in Scotland, it is important to take into account the split between owner occupation and tenancy, since different arrangements are in place for housing adaptations in public and private sectors. The rate of owner occupation in Scotland has traditionally been lower than in England (see Figure 5.1). In 1997 according to Social Trends data, 58% of Scottish householders owned their own homes, compared with 67% in England. By 1999, the Scottish figure had risen to 61% (Goodlad, 2000). Despite this surviving disparity, Goodlad notes a growing trend towards convergence between the two countries. Twenty years ago, Scotland had a majority of its householders living in public sector housing, but now two thirds live in the private sector. In England, there has always been a higher rate of owner occupation due to the greater wealth of the country. Although there has been a growth in owner occupation, the shift to the private sector in England has not been nearly so marked.
**Figure 5.1: Housing tenure patterns in Scotland and England: 1997**

Housing tenure patterns in Scotland and England (Sources: JRF Findings and Scottish Homes Scottish House Condition Survey)

- **Social rented**
  - Scotland
  - England

- **Private rented**
  - Scotland
  - England

- **Home ownership**
  - Scotland
  - England

**Figure 5.2: Disabled people and tenure patterns in Britain**

Disabled people and tenure patterns in Britain (Sources: OPCS, 1998 and social trends 7, 1997)

- **Social rented**
  - Britain
  - Disabled people

- **Private rented**
  - Britain
  - Disabled people

- **Home ownership**
  - Britain
  - Disabled people

**Figure 5.3: Home Ownership in Great Britain and Scotland for Total Population and Disabled People**

Tenure patterns: Scotland and England (Sources: Martin and White, 1988 and Social trends 27, 1997)

- **Great Britain**

- **Scotland**

- **Disabled people in Britain**

- **Disabled people in Scotland**
Figure 5.2 shows that across GB, disabled people are less likely to be owner occupiers than non-disabled people and are more likely to be in public or private rented accommodation. Figure 5.3 shows that disabled people in Scotland are less likely to be owner occupiers than disabled people in England.

Right to Buy policies were introduced by a previous Conservative administration and gave tenants in the public sector the opportunity to buy their home at a discounted price depending on the amount of time in which they had lived in the house as tenants. It appears that disabled people were less likely to take up the right to buy than others. At the same time, the effect of the policy was that the most desirable properties tended to be bought, leaving poorer housing stock available for rent. The Scottish Household Survey (1999) showed that 41% of families living in disadvantaged council estates housed some one that had a long-standing illness, health problem or disability that limited their daily activity or the type of work they could do.

**Rights of disabled people**
The Disability Discrimination Act places a duty on local authorities, housing association landlords and private sector landlords not to treat a disabled person less favourably than they would a non-disabled person. However, the DDA does not place a legal duty on someone selling, letting or managing premises, which can include dwelling houses, flats and bed-sits, to make reasonable adjustments to those premises. Herd (1999b) maintains that:

> The combined effect of the duty not to treat people less favourably in relation to a service but the absence of a duty to reasonably adjust premises results in an anomalous position for housing providers. (Herd, 1999b: 32).

New building regulations which will require houses to comply with specified access standards will apply only to new housing stock.

**Responsibilities for adaptations and improvements**
Although the DDA is somewhat limited in extending the rights of disabled people in the area of housing, some rights to adaptations and improvements already exist. The Chronically Sick and Disabled Persons (Scotland) Act 1972 requires local authorities with responsibility to ‘chronically sick and disabled people’ under the Social Work (Scotland) Act 1972 to make arrangements for:

- Practical assistance for the disabled person in her or his home.
- Assistance in arranging for the carrying out of works of adaptation in a person’s home or the provision of any additional facilities designed to secure greater safety, comfort or convenience.

The Housing (Scotland) Act 1987 allows an owner occupier in a household with a disabled family member to apply to the local authority for a home improvement grant to make housing adaptations such as the installation of a ramp, bathroom or kitchen alterations. If a disabled person or a householder with a disabled family member is in private sector rented accommodation, they may ask their landlord to apply for a home improvement grant. Local authorities vary in their response to such applications and may require the person to make a financial contribution depending on the person’s circumstances and local authority policy on charging for services. If an adaptation is required to a local authority or housing association dwelling, then the home improvement will be funded from the Scottish Homes budget or the local authority’s housing revenue budget. An issue which has been highlighted by the Disabled Persons’ Housing Service, Lothian, is that rather poor use is made of houses which have been adapted. For instance, only 40% of houses adapted for wheelchair use are inhabited by wheelchair users. Local authorities also run Care and Repair schemes which help people receiving care in the community to get minor household repairs done in order to help them stay in their own homes.

**Responsibilities of local authorities: Housing Plans and Community Care Plans**

Local authorities have responsibilities to produce Housing Plans which outline their strategy for monitoring and improving their housing stock to meet the needs of disabled people and other groups. Housing plans produced by local authorities clearly indicate that there is a shortfall between the amount of adapted housing available and disabled people’s needs.

Local authorities also have a corporate responsibility to produce community care plans which should involve key agencies including social work, health, housing and education. The Scottish Office’s document *Modernising Community Care* (Scottish Office, 1998) indicated that there was a need for services to be better geared to the needs of service users and less dictated by agency boundaries. The Government stated its intention to target social work resources on authorities which were shifting the balance of care from institutions to flexible home care services. This theme was restated in the Scottish Executive’s document *The Same as You? A Review of Services for People with Learning Disabilities* (Scottish Executive, 2000d). Over coming years as long-stay hospitals finally close, it is envisaged that money
will be transferred from health boards to local authorities to ensure that accommodation is available for people in ‘homely settings in the community’.

The document *Modernising Community Care: The Housing Contribution* (Scottish Office, 1999g) emphasised that the role of housing was just as important as that of social work and health in the delivery of community care. Community care plans should be consistent with housing plans and should focus on short and long term objectives with clearly measurable outcomes.

Scottish Homes published its latest community care policy in 1998. The policy includes commitments to:

- Fund new housing which is appropriate, integrated in the community, which offers choice, flexibility and control to the individual and which is sustainable in the long term.
- Focus investment on ordinary self-contained housing, designed to barrier-free standards, or with additional design specifications to meet the physical requirements of the intended household.
- Promote the best use of existing housing through appropriate allocation policies and which recognise the value of adaptations and Care and Repair schemes.

**Housing benefits**

Many research studies have noted that housing benefits tend to mitigate against disabled people living more independent lives and participating in the labour market (see literature review below). The Government’s Supporting People initiative is intended to examine the interaction of housing and other social security benefits with a view to using funds more efficiently and removing dependency traps. Whilst the end result of the problem is almost universally recognised and is acknowledged in one of the recommendations of the Learning Disabilities Review, the UK social security system is immensely complicated and no way has yet been found of ensuring that housing benefits promote independence.

**Better Homes for Scotland’s Communities and the Housing (Scotland) Act 2001**

The Green Paper *Better Homes for Scotland’s Communities* (Scottish Executive, 2000) and the new Housing (Scotland) Bill are geared towards a number of strategic alterations in the provision of social housing and the relationship between social and private sectors. Key provisions include:

- converting Scottish Homes into an executive agency of the Scottish Executive
- enhancing the strategic role of local authorities
• reforming the Right to Buy
• creating a single regulatory framework for all social landlords.

Some provisions of the Bill have implications for disabled people, for instance:
• the creation of new local strategic housing budgets
• the establishment of new duties for registered social landlords in relation to homelessness
• the reform of repairs and improvement grants to introduce a test of resources
• new funding arrangements to support housing management costs of people with special needs.

A section of the Bill focuses on homeless people and puts in place measures to allow social landlords to prioritise the housing needs of this group. It has been suggested that disabled people might be seen as the hidden homeless because, although technically in some form of housing, they are often in highly unsuitable accommodation. In addition, some rough sleepers have mental health problems, learning disabilities, physical disabilities or progressive conditions. Given the overlap between disabled people’s experiences of housing and those classified as homeless, it has been suggested that the housing needs of disabled people should also be prioritised.

**Moves to inform disabled people of their rights**

As we noted in the Introduction, disabled people are less likely than others to be owner occupiers. A voluntary organisation, Ownership Options, has been established to inform and support disabled people in buying their own homes and was identified as an example of good practice in the Learning Disabilities Review.

The Disabled Persons Housing Service Lothian develops Personal Housing Plans and provides a focal point for information and advice. Data from Personal Housing Plans are collated and analysed to provide information on disabled people’s housing needs in Edinburgh and the Lothians. In the future there are plans to act as brokers for the sale and exchange of owned or rented properties with adaptations. The aim is to ensure that a higher proportion of adapted properties are used by people requiring adaptations, thus assisting both disabled people and housing providers. Disabled Persons Housing Services have also been established in Renfrewshire and Glasgow. Groups such as this are able to play a vital role in pushing local
authorities to improve the information they provide to disabled people as well as improving new and existing housing stock.

OFFICIAL STATISTICS

In the following section, we offer a brief commentary on the type of data available in relation to housing for disabled people in Scotland. The information is drawn from a range of sources, and it is evident that it provides an extremely partial picture of the nature and quality of housing for disabled people in Scotland. As noted at the start of this chapter, most disabled people live in social housing and a lower proportion of disabled people are owner occupiers than is the case in the rest of GB.

Table 5.1 indicates that disabled people in social housing are more likely to live in local authority provision than Scottish Homes dwellings. Given the changed status of Scottish Homes following the new Housing Act and the commitment of the agency to the provision of high quality homes for people with community care needs, it will be important to assess the extent to which Scottish Homes makes a greater contribution in the future.

Table 5.1: Housing for disabled people: provision by public agencies and housing associations as at 31st March 1999: by agency

<table>
<thead>
<tr>
<th>Agency</th>
<th>Housing for disabled people</th>
<th>Houses for wheelchair users</th>
<th>Houses for people with some mobility problems</th>
<th>Other specially adapted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3,046</td>
<td>7,759</td>
<td>10,047</td>
<td></td>
<td>20,852</td>
</tr>
<tr>
<td>All Public Agencies</td>
<td>1,172</td>
<td>7,157</td>
<td>8,744</td>
<td></td>
<td>17,073</td>
</tr>
<tr>
<td>Local Authority</td>
<td>1,141</td>
<td>7,147</td>
<td>8,666</td>
<td></td>
<td>16,954</td>
</tr>
<tr>
<td>Scottish Homes</td>
<td>31</td>
<td>10</td>
<td>78</td>
<td></td>
<td>119</td>
</tr>
<tr>
<td>Housing Associations</td>
<td>1,874</td>
<td>602</td>
<td>1,303</td>
<td></td>
<td>3,779</td>
</tr>
</tbody>
</table>

Source: Housing Statistics, SEDD

1 Figures from previous years have been used where returns for 1999 are outstanding.
2 Figures are now client based so they may rise or fall.
Table 5.2 shows the number of houses for elderly and disabled people in Scottish local authorities. Overall, most disabled people live in accommodation owned by local authorities. However, in a significant number of authorities the majority of housing for disabled people is owned by housing associations rather than local authorities.
<table>
<thead>
<tr>
<th>Authorities</th>
<th>Sheltered Housing</th>
<th>Amenity and/or Wheelchair Housing</th>
<th>Other disabled or adapted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>2,092 366 383 1,157</td>
<td>221 951 39</td>
<td>64 2 788 7 14</td>
</tr>
<tr>
<td>Aberdeeneshire</td>
<td>1,402 857 159 2,664</td>
<td>262 340 176</td>
<td>17 0 330 70 0</td>
</tr>
<tr>
<td>Angus</td>
<td>600 445 30 736</td>
<td>172 908 17</td>
<td>26 0 22 49 0</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>233 389 0 241</td>
<td>122 308 36</td>
<td>26 58 349 15 35</td>
</tr>
<tr>
<td>Clackmannan</td>
<td>134 193 0 205</td>
<td>158 0 101</td>
<td>0 0 362 17 33</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>298 398 111 629</td>
<td>256 0 2</td>
<td>16 0 10 6 0</td>
</tr>
<tr>
<td>Dundee City</td>
<td>3,289 779 164 346</td>
<td>501 99 67</td>
<td>109 41 3,973 35 97</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>400 151 19 815</td>
<td>57 0 25</td>
<td>13 0 49 3 0</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>141 296 71 681</td>
<td>0 273 0</td>
<td>0 0 8 0 0</td>
</tr>
<tr>
<td>East Lothian</td>
<td>146 308 127 1,304</td>
<td>184 478 2</td>
<td>26 0 0 2 0</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>281 127 682 270</td>
<td>23 0 26</td>
<td>12 0 4 0 0</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>1,288 2,567 1,061 754</td>
<td>459 14 29</td>
<td>204 0 350 96 0</td>
</tr>
<tr>
<td>Falkirk</td>
<td>332 402 84 843</td>
<td>81 0 31</td>
<td>17 0 1,560 791 0</td>
</tr>
<tr>
<td>Fife</td>
<td>1,250 656 0 2,505</td>
<td>320 0 124</td>
<td>42 0 175 29 0</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>1,696 3,225 0 13,241</td>
<td>380 0 38</td>
<td>229 0 8,250 195 0</td>
</tr>
<tr>
<td>Highland</td>
<td>543 448 0 1,229</td>
<td>134 92 64</td>
<td>16 7 261 35 100</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>228 248 0 568</td>
<td>154 226 22</td>
<td>7 0 140 2 0</td>
</tr>
<tr>
<td>Midlothian</td>
<td>22 274 0 224</td>
<td>330 164 30</td>
<td>22 0 135 19 40</td>
</tr>
</tbody>
</table>
### Table 5.2 Cont.: Housing for elderly and disabled people by Scottish authority 1997

<table>
<thead>
<tr>
<th>Authorities</th>
<th>Sheltered Housing</th>
<th>Amenity and/or With alarm</th>
<th>Wheelchair Housing</th>
<th>Other disabled or adapted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moray</td>
<td>150</td>
<td>328</td>
<td>0</td>
<td>1,100</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>537</td>
<td>163</td>
<td>90</td>
<td>1,585</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>983</td>
<td>580</td>
<td>0</td>
<td>300</td>
</tr>
<tr>
<td>Orkney Islands</td>
<td>44</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Perthshire &amp; Kinross</td>
<td>428</td>
<td>476</td>
<td>128</td>
<td>1,054</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>459</td>
<td>309</td>
<td>15</td>
<td>1,237</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>229</td>
<td>849</td>
<td>81</td>
<td>6</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>302</td>
<td>12</td>
<td>0</td>
<td>312</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>616</td>
<td>241</td>
<td>191</td>
<td>789</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>1,210</td>
<td>419</td>
<td>69</td>
<td>3,952</td>
</tr>
<tr>
<td>Stirling</td>
<td>202</td>
<td>291</td>
<td>76</td>
<td>397</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>295</td>
<td>183</td>
<td>0</td>
<td>977</td>
</tr>
<tr>
<td>West Lothian</td>
<td>105</td>
<td>536</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Western Isles</td>
<td>153</td>
<td>59</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Scotland</td>
<td>20,089</td>
<td>16,548</td>
<td>3,541</td>
<td>40,041</td>
</tr>
</tbody>
</table>

**Source:** Scottish Office statistics

**Notes:** Public sector comprises local authority and Scottish Homes dwellings. Sheltered dwellings include very sheltered, adapted and wheelchair sheltered dwellings. Amenity, alarm and wheelchair dwellings include those with adaptations.
Figure 5.4 shows that, according to the Scottish House Condition Survey 1996, adaptations were present in 254,000 (12% of dwellings). Most dwellings with adaptations (57%) had only one adaptation. The most common adaptations were handrails, installation of an emergency alarm system and an adapted bathroom.

Around 110,000 (5%) of households including a person with a long-term illness or disability said that they required adaptations. In 71% of cases the household requested only one adaptation; 19% requested two and 10% requested three or more. The most requested adaptation was an adapted bathroom, followed by handrails inside and outside and a hoist or stairlift.

Approximately 24,000 (1.1%) of dwellings in Scotland were suitable for use by people with some mobility problems. This figure includes 18,000 dwellings that were suitable for those using a wheelchair on a temporary basis, which in turn includes 5,000 dwellings suitable for use by full-time wheelchair users (however, only 40% of houses suitable for wheelchair users were occupied by wheelchair users). The post-1982 stock performed best in terms of meeting provision standards, but still only 3.4% met the...
barrier free standard. Inadequate bathrooms and/or insufficient internal circulation space accounted for 45% of the dwellings which failed to achieve the standards required for people with some mobility difficulties.

There were approximately 124,000 households including individuals with some mobility difficulties compared to 24,000 dwellings suitable for this group. There are approximately 20,000 households where a household member uses a wheelchair compared to 5,000 dwellings of full wheelchair standard and 18,000 dwellings of temporary wheelchair standard. Of the 24,000 dwellings classed as suitable for people with some mobility difficulties, 2,000 were occupied by households where one or more household members used a wheelchair and a further 3,000 were occupied by households where one or more household member used a walking stick or frame. It is evident that many adapted houses are occupied by people who do not require such housing, whilst many people requiring adaptations have to wait for an adaptation to be made. If there was a system for matching a disabled person to a suitably adapted house in both social and private sectors, far greater efficiency would be achieved.

Overall, there is a mismatch between demand for and provision of adapted housing. Firstly, there is an overall shortage of adapted housing and secondly, houses which have been adapted are often occupied by people who do not require such adaptations. The summary of official statistics presented above indicates that data are currently gathered in a patchy way using administrative categories which do not provide a clear overview of the nature of housing suitable for different groups of disabled people. Data tend to be available for ‘community care’ populations for whom local authorities have a statutory responsibility. Far less is known about housing for disabled people who do not fall into the category of ‘special needs’ or ‘community care’ populations. Many local authorities lack good data on adaptations to public sector housing association and private housing stock. This is likely to lead to inefficiencies, as local authorities fail to track the houses which they have paid to be adapted.

**REVIEW OF RESEARCH**

There are a number of university-based groups conducting research into housing policy, but until recently there has not been a major focus on disabled people and housing. Over the last few years, interest in disabled people’s experience of housing policy has grown and there are now a number of studies which can be drawn upon.
Disabled People and Housing in Scotland
The most recent and comprehensive study of disability and housing in Scotland was conducted by the Housing Reference Group for Scotland, (Herd, 1999b). In addition to outlining the policy context of housing provision for disabled people in Scotland and describing patterns of owner occupation and tenure, the report identified a number of barriers to equality of housing opportunity for disabled people in Scotland. These include:

- A chronic shortage of barrier-free and wheelchair accessible accommodation.
- An unhelpful division between mainstream and specialist housing.
- Lack of information about accessibility of private sector housing.
- Poor information relating to local authority housing (Housing Associations have better information).
- Patchy data on housing need.
- Little expertise and few resources committed to matching people with needs to available housing.
- Too few information and advice agencies, with the result that disabled people do not know their rights.
- Lack of knowledge of barrier free housing among builders and architects, who often lack training in this area.
- Lack of knowledge among financial institutions about how private ownership may work for disabled people.
- Lack of disability awareness among housing workers.
- Local authorities are not aware of their legal responsibilities to provide adequate housing for disabled people.
- Community Care assessments may ignore housing requirements.
- Homelessness often means not having a roof. Disabled people without proper housing might be considered homeless in the sense that they lack adequate housing.
- Planning permission processes do not give adequate consideration to access matters.
- The equal opportunities provisions of some housing providers do not pay sufficient attention to the position of disabled people.
- Disproportionately low numbers of disabled people are involved in providing housing services.
- Many private sector landlords refuse to rent housing to people on benefits.
- Disabled people need to live in areas where they can access all the facilities of the neighbourhood.
- There is sometimes opposition by local residents to the building of
houses for people with learning difficulties and mental health problems.  
- Council house sales in the 1980s removed accessible and adaptable properties from the social rented sector in which most disabled people seek housing.

Recommendations include the following:
- All new houses should be built to the highest standards of accessibility.
- Building regulations should be reviewed to increase the minimum standard for accessible design.
- A duty should be placed on local authorities to procure equality of housing opportunity across all tenures for people living in their area. Local authorities should be required to specify levels of housing inequality experienced by disabled people.
- Local authorities should be required to produce plans which indicate how equality of housing opportunity is to be achieved.
- Scottish Homes and/or The Scottish Executive should commission work which leads to the development and use of reliable tools for estimating the unmet need for new and adapted housing required by disabled people in Scotland.
- All housing providers should be required to monitor their housing stock and know the current circumstances of their accessible, adapted and adaptable properties.
- Local authorities should take the lead role in co-ordinating inter-agency, cross-sector networks of housing providers, organisations representing housing service users and planners to co-ordinate local responses to demand and need.
- The Scottish Executive should commission research to produce reliable estimates of the current number and circumstances of disabled people in Scotland.
- The Scottish Executive should work closely with and support organisations such as the Disabled Persons Housing Service. Similar information services should be established to provide advice and information which is comprehensive, accurate, knowledgeable and reliable.

The Housing Needs of Community Care Groups
As we noted earlier, the Scottish Executive is committed to the closure of long-stay hospitals for people with learning difficulties by 2005 (Scottish Executive, 2000d). There is also a desire to move people with mental health problems out of large hospitals and into community-based settings. However, there is considerable evidence that there is a lack of adequate
community-based living arrangements coupled with opportunities for meaningful day-time activities. Stalker and Hunter (1999) reported on a study of the resettlement programme for people with learning difficulties in Scotland. They found that the resettlement programme was having severe operational difficulties, with problems in planning, financial arrangements and inter-agency collaboration. Most hospitals planned to continue some level of activity or transform their services rather than close down completely. Stalker and Hunter concluded that there is a risk of hospitals continuing in alternative guises, particularly through the activities of NHS Trusts and of people with dual labels remaining resident in them for many years. Petch et al (2000) in a study funded by Scottish Homes, interviewed people with learning disabilities and mental health problems. Respondents reported that there was a shortage of supported homes in the community for individuals and small groups, with the result that many were in unsuitable accommodation.

Titterton (2000), in a review paper for the Joseph Rowntree Foundation, reported significant difficulties in shifting the ‘balance of care’ between hospital, residential and community forms of service provision. In Titterton’s view, community-based forms of residential provision for both people with mental health problems and those with learning difficulties are seriously deficient. The focus has tended to be on more able people, and there is a particular dearth of accommodation for people with higher support needs, including challenging behaviours.

Titterton noted that the number of people in psychiatric hospitals decreased from a total 14,240 to 10,220 between 1986 and 1996, representing a decrease of 10%. Within the same period, the numbers of people with mental health problems staying in group homes increased from 570 to 1,150, representing a two fold increase. For the same period, the number of people with learning disabilities in hospital decreased by 40%, falling from 5,290 in 1986 to 3,220 in 1996. Numbers of those staying in group homes doubled from 1,810 in 1986 to 4,080 in 1996. Compared with England and Wales, Scotland has much higher use of long stay hospitals for people with mental health problems and learning difficulties. In relation to people with mental health problems, Scotland has 153 people in long stay psychiatric hospitals per 100,000 people, compared with 29 in England and 51 in Wales. Sixty one people per 100,000 population are placed in long stay hospitals for people with learning difficulties, compared with 24 in England and 30 in Wales. Titterton (2000) suggests that the Scottish preference for institutional placements is to do with administrative, professional and
cultural legacies, the balance of spending, and the corresponding underdevelopment of community-based services.

A number of researchers have demonstrated the way in which arrangements for the payment of housing benefit has had an impact on opportunities for disabled people to experience greater independence. Wilson, Riddell and Baron (2001) discuss the impact of ‘preserved rights’ on the housing and employment opportunities for people with learning disabilities in Scotland. Some voluntary organisations providing supported accommodation for people with learning disabilities receive a block grant from Health Boards, with a guarantee that this level of funding will continue in relation to those whose housing costs were being paid for by health prior to the advent of community care policies. As a result of this guaranteed funding, there is little incentive for them to encourage individuals to move into more independent living arrangements, since this would destabilise the organisation’s finances.

At a UK level, the perverse incentives towards reduced levels of independence created by the interaction of housing benefit and income support have been documented by a series of studies funded by the Joseph Rowntree Foundation (see Simons, 1998, and Watson, 1997, for a summary of 21 studies on housing and community care funded by the Joseph Rowntree Foundation). The Government’s Supporting People programme is intended to simplify the funding of benefits for ‘vulnerable people’ with a review to identifying and removing dependency traps. A review of the Supporting People programme by Griffiths (2000) examined the extent to which the programme was succeeding in making the right connections to strengthen support for independent living. In particular, the report examines the Transitional Housing Benefit scheme which will provide much of the funding for the Supporting People Programme. Under existing programmes, it appears that many disabled people will be expected to use their Disability Living Allowance to fund supported accommodation. The review recommends that charging should be scrapped so that disabled people in such accommodation are left with a reasonable weekly disposable income.

Housing and disabled children
There has been little research in Scotland on housing for disabled children and their families. However, research conducted by Beresford and Oldman (1998) found that disabled children and their families in the North of England had many unmet housing needs. Mitchell and Sloper (2000) in an English study found that parents of disabled children were not given adequate
information on housing, including possibilities for the funding of adaptations and improvements.

ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES

The previous review of policy, official statistics and research literature suggests that there is a need to address the issue of ‘joined up policy’ for people who are regarded as ‘community care’ populations. The dependency traps created by current housing benefits arrangements mean that many vulnerable disabled people are stuck in accommodation which prevents them achieving a greater degree of independence, including moving into employment. The Supporting People programme will be critical in terms of simplifying benefits arrangements. In addition, there is clearly a need to invest in accommodation for people leaving long stay institutions so that they do not simply move into new forms of residential provision which provide few opportunities for independence. Small group homes offering support, rather than nursing homes or other sorts of residential provision, are likely to offer better value as well as greater independence (Scottish Executive, 2000d). Better inter-agency working between housing, social work, health, employment and education personnel is essential to make independent living a reality rather than a pious hope.

The new roles for housing associations and local authorities envisaged by the Housing (Scotland) Bill will be critical in improving the experiences of disabled people in relation to housing. It is expected that housing associations will grow in importance as providers and will develop further their expertise in involving tenants in important strategic and practical decisions. Local authorities are to have an important role in terms of strategic planning. This means that they will have to improve their data gathering capacity, advancing their awareness of the needs of the disabled people they are serving and of their housing stock in both social and private sectors. In particular, they will need to keep much better records of the adaptations and improvements they have funded, and find ways of matching tenants to properties.

There are currently planned developments to building regulations to ensure that new-build housing is barrier free. It will be vital for local authorities to ensure that they are well informed of such changes so that the housing stock in their area, whether in the social or private sectors, becomes more inclusive.
Of great importance for the future is the work undertaken by Ownership Options in campaigning for greater access to home ownership for disabled people. As noted above, this voluntary organisation, along with groups such as the Disabled Persons Housing Service in Lothian and Glasgow, has undertaken pioneering work in informing disabled people of a range of housing options including home ownership. The Adults with Incapacity (Scotland) Act 2000 allows an individual to apply to the Sheriff Court for an Intervention Order in order to allow them to undertake a particular action on behalf of a person deemed an ‘incapable adult’. Such an action might include purchasing a home on behalf of another person. This suggests that home ownership might become possible for a much larger group of disabled people.

Future research is needed to address the following questions:

• How effective is the Supporting People programme in terms of synchronising housing and income benefits to facilitate independent living?

• To what extent is housing an integral part of community care planning? Are housing, health and social care services inter-connecting to provide support for disabled people in ‘homely settings in the community’?

• What impact will the new Housing (Scotland) Bill have on the future roles of housing associations and local authorities in planning and providing housing services for disabled people?

• What patterns emerge over time in relation to the number and quality of houses adapted for use by disabled people in social and private sectors?

• What are the long-term housing needs and experiences of different groups of disabled people in Scotland in relation to gender, age, social class, ‘race’ and geographical location?

• How does the quality of housing affect the lives of families with a disabled child?
6: DISABLED PEOPLE AND TRANSPORT

INTRODUCTION

Until recently, transport policy in Scotland developed with scant regard to
the interests of disabled people. It is now recognised that transport lies at
the heart of social inclusion. Without access to convenient transport, people
are likely to be deprived of access to education, employment, health and
leisure services. Whilst transport policy in the 1980s veered towards
deregulation, during the late 1990s there was a new recognition that
transport planning is essential to the social inclusion of disabled people and
other groups. The Central Research Unit commissioned a study of transport
for disabled people in Scotland (Henderson and Henderson, 1999) and the
review below draws extensively on this work.

CURRENT POLICY

As noted above, Scotland’s transport infrastructure was designed without
considering the needs of disabled people. For example, Glasgow’s
underground system is inaccessible to disabled people and many bus and
railway stations were built in inaccessible locations. During the 1980s and
early 1990s, the deregulation of public transport meant that systems became
less rather than more co-ordinated. Investment in roads and the rapid growth
in car ownership, coupled with withdrawal of resources from public transport,
meant that those who lacked access to a car were especially disadvantaged.
Disabled people were particularly likely to fall into this group. Data from a
survey of 6,500 people in the West of Scotland drawn randomly from the
electoral role (Macintyre et al, 2000) showed that 39% of car-owners had a
long-standing illness or disability compared with 61% of non-car owners.
Private bus companies were reluctant to share their development plans
with others, since this was regarded as commercially sensitive information.
Throughout privatised transport services, the priority shifted from that of
providing a service to the public to that of returning a profit to shareholders
and problems were particularly acute in rural areas.

The first major piece of transport-related legislation to have a specific focus
on the needs of disabled people was the London Regional Transport Act in
1984, which led to the setting up of the Unit for Disabled Passengers and
improved the accessibility of London transport for disabled people. The
Transport Act of 1985 stated that authorities having responsibility for
passenger transport must take account of the needs of disabled people
when exercising their responsibility. This Act was limited in its scope, and did not require all transport to be accessible. The Act led to the creation of the Disabled Persons’ Transport Advisory Committee (DPTAC), established to advise the government on transport policy issues facing disabled people.

**The Disability Discrimination Act 1995**

The Disability Discrimination Act makes it unlawful to discriminate in the provision of transport infrastructure (e.g. airports, ferry terminals, bus stations, railway stations) but not in or on the transport itself. In relation to infrastructure, transport providers must not discriminate against disabled people and from October 1999 must make ‘reasonable adjustments’ where necessary in order not to discriminate (e.g. changing policy and practice, providing auxiliary aids and services and providing services by a reasonable alternative method).

The DDA requires a minimum standard of access to new public transport vehicles and imposes a statutory requirement that some forms of public transport be accessible to disabled people. A number of dates have been set for compliance. New public transport vehicles had to comply with accessibility standards by January 2000 and existing vehicles by later dates (2015 for single deck vehicles and 2017 for double deck vehicles). Some vehicles, e.g. those operated by voluntary groups and some other specific forms of transport including ferries and aeroplanes are exempt. In relation to taxis, the Act allows the government to make regulations covering new taxis and newly licensed taxis and eventually all taxis will be required to comply. It is possible, however, for a licensing authority to apply for exemptions where total compliance would lead to an unacceptable drop in the number of taxis available.

**UK and Scottish White Papers**

In 1998 the Government published a White Paper on transport for disabled people (DETR, 1998) and a Paper for Scotland entitled *Travel Choices for Scotland* (Scottish Office, 1998). The UK White Paper provided a framework for sustainable, integrated transport and the Scottish paper dealt with the integration of different forms of transport as well as emphasising the need for a greater degree of cohesion between different areas of social policy. The White Paper proposed the creation of Quality Partnerships, in which bus companies and local authorities work together to develop infrastructure, vehicles, training and information systems. In addition, local transport strategies are intended to provide opportunities for improving access.
The White Paper *Travel Choices for Scotland* noted that the Scottish Parliament has full legislative responsibility for a range of transport related issues particularly those at a local level, although the setting of standards and regulations remains a UK matter. The Transport (Scotland) Act 2001 legislates for the establishment of Quality Partnership Schemes and also gives Scottish ministers the power, by regulations, to establish a committee to advise on the transport needs of disabled people.

**REVIEW OF RESEARCH**

**Transport for disabled people in Scotland**

Because of the privatisation of public transport during the 1980s, the Government has been unable to maintain a database of official statistics. Many private operators are reluctant to provide public bodies with information on their activities since this is regarded as commercially sensitive. In the following sections, we first look at the limited evidence which is available on the accessibility of public transport. Subsequently, we discuss data on children and road traffic accidents, since it is important to remember that road accidents are significant creators of impairment. A major piece of work on access to transport for disabled people in Scotland was commissioned by the Central Research Unit and undertaken by Henderson and Henderson (1999) and some of its key findings are discussed below.

Table 6.1 shows that only a very small proportion of buses (12%) have low floors and are therefore accessible to people who are wheelchair users.
Table 6.1: Transport provision for physically disabled people travelling by bus in Scotland 1998

<table>
<thead>
<tr>
<th>Bus types in operation</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High floor</td>
<td>5,193</td>
<td>87.6</td>
</tr>
<tr>
<td>Low floor</td>
<td>732</td>
<td>12.4</td>
</tr>
<tr>
<td>Of which</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kneel</td>
<td>600</td>
<td>82.0</td>
</tr>
<tr>
<td>Manual ramp</td>
<td>91</td>
<td>12.4</td>
</tr>
<tr>
<td>Automatic ramp</td>
<td>36</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Low floor bus operation

| Current operation low floor buses | 48 | 25.9 |
| Intent to operate low floor buses in next 3 years | 24 | 13.0 |
| May operate low floor buses in next 3 years | 22 | 11.9 |
| Do not intend to operate low floor buses in next 3 years | 91 | 49.2 |

Source: Transport provision for disabled people in Scotland, Reid Howie Associates, 1999
Note: Contact was made with all Scottish providers of bus services, as far as they could be identified.

Travel by rail for many disabled people is equally difficult. Table 6.2 shows that 35% of railway stations in Scotland are inaccessible or only partially accessible.

Table 6.2: Transport provision for physically disabled people at railway stations in Scotland, 1999

<table>
<thead>
<tr>
<th>Access at railway stations</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccessible</td>
<td>52</td>
<td>15.6</td>
</tr>
<tr>
<td>Partly accessible</td>
<td>63</td>
<td>18.9</td>
</tr>
<tr>
<td>Accessible</td>
<td>219</td>
<td>65.6</td>
</tr>
<tr>
<td>Ramps at railway stations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ramps always available</td>
<td>82</td>
<td>24.5</td>
</tr>
<tr>
<td>Ramps available by prior arrangement</td>
<td>35</td>
<td>10.5</td>
</tr>
<tr>
<td>No Ramp available</td>
<td>217</td>
<td>65</td>
</tr>
</tbody>
</table>

1 Figures come from ScotRail and Railtrack who re-assessed the accessibility of all stations in Scotland using the most up to date standards contained in DDA or DPTAC publications (among other sources).
2 This largely relates to platforms. It should be noted that only 15% of stations have accessible toilets, and only 22% have marked parking spaces.

3 Questionnaires were sent to each of the train operating companies active in Scotland.

4 This includes the 190 unstaffed stations in Scotland 1998. However, this fact will change this year as a consequence of the fact that ramps will be deployed on trains rather than placed at stations.

The research also found that there were significant variations across the country in terms of the availability and accessibility of services, strategies to improve services, staff training and information for particular groups of disabled people. The report recommended the establishment of a national partnership to consider access to public transport comprising public transport interests, disability groups and policy makers. Local audits of services were recommended, along with better training and information systems, greater consultation with disabled people, and the establishment of a national passenger watchdog body to address key issues.

Data from the Scottish Household Survey have been used to examine the age profile of those having difficulty in accessing transport. Figure 6.1 shows that walking and using a bus, train or car are reported as being more difficult by people in the 65+ age group. Although using a car is seen as less difficult than using a train, bus or walking, older people are less likely to have a car than those in younger age groups.

**Figure 6.1: Activities found difficult by age group**

![Graph showing the difficulty of activities by age group]

*Source: Scottish Household Survey 1999*
Children and road traffic accidents: the creation of disability

In this section, our focus shifts to some of the consequences of the move from public to private transport systems in terms of child death and injury on the road. Evidence discussed here provides some insight into how transport policy decisions have knock-on effects in terms of the social creation of disability. It is clear that risk is concentrated on people living in socially disadvantaged neighbourhoods, the group who are least likely themselves to own a car and who may be poorly served by public transport.

Research has been undertaken to investigate the increased rate of accidents of children living in disadvantaged areas (White et al, 2000). Scotland has a relatively high child pedestrian death rate. In 1997, 3,795 children were killed or injured on road traffic accidents, of whom 1,892 were pedestrians. The review of evidence found that:

- In understanding factors affecting road accident rates in children, it is difficult to separate out effects of household from effects of neighbourhood.
- The risk of death for child pedestrians is highly class related. Children in the lowest socio-economic group are over 4 times more likely to be killed as pedestrians than their counterparts in the highest socio-economic group.
- The decline in child death rates over time has been less marked for children in the manual social classes than for children in the non-manual social classes and, as a consequence, the socio-economic mortality differentials have increased.
- Injuries to child pedestrian casualties from socio-economically disadvantaged families tend to be of greater severity.
- The risk of pedestrian injury is over 50% higher for those children of single parents, compared with those in two parent families.
- Significant differences in child pedestrian injury rates based on ethnicity have been identified, particularly for younger non-white children.
- On journeys to and from school, deprived children are exposed to greater risk than more affluent children as they are less likely to travel to school by car or to be accompanied by an adult.
- Restricted access to play space and proximity of housing to busy roads, compounded by a lack of supervision in younger children appear to exacerbate road accident rates in disadvantaged areas.
ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES

Whilst the DDA and the provisions of the Transport (Scotland) Act 2001 are likely to lead to improvements in infrastructure, there are clearly important further developments required. The deadlines set by government for all public transport vehicles to be accessible to disabled people are far into the future and some modes of transport (ferries, aeroplanes) are not covered by the DDA. The effectiveness of the new partnership arrangements between public and private sectors in developing integrated transport systems remains to be seen. In particular, firmer legislative measures may be needed to get privatised bus and railways to prioritise accessible transport, backed up by appropriate staff training and information systems.

It is evident that there is a dearth of statistical evidence which may be used to monitor future progress in this area. It will be important for the UK Government and the Scottish Executive to decide what information is needed to assess the impact of the DDA on access to transport for disabled people and to ensure that such information is gathered and analysed on a regular basis. Whilst some evidence is available on access to trains and buses by particular groups of disabled people, primarily people with physical impairments, much less is known about access issues for people with mental health problems and learning difficulties. For the latter group, support in understanding timetables and travelling from one place to another is likely to be of central importance.

Key research questions to be addressed include the following:

- What is the impact of the new DDA regulations on standards of accessibility for public transport vehicles?
- Given the responsibilities of the Scottish Executive and local authorities to plan integrated transport systems, how effective are these in meeting the needs of disabled people?
- What are disabled people’s perspectives on the wider impact of transport on their lives (e.g. in relation to employment, education, leisure). How do these perceptions vary according to geographical location, gender, social class, age and ‘race’?
- What issues arise for disabled people with specific impairments e.g. physical or sensory impairments, learning difficulties, mental health problems?
- How accessible are transport systems within Scotland and in different parts of the UK?
INTRODUCTION

Part III of the Disability Discrimination Act deals with access to goods, facilities and services for disabled people. The Act applies to everyone providing services to the public in the public, private and voluntary sectors, regardless of whether the service is free (such as access to a library) or in return for payment (for example a drink in a pub). This chapter begins by outlining the provisions of the DDA and subsequently summarises existing information on the extent to which disabled people are able to access goods and services. Finally, the chapter considers the future impact of the implementation of the final stages of the DDA relating to goods and services.

CURRENT POLICY

Part III of the Disability Discrimination Act makes it unlawful for those who provide goods, facilities and services to discriminate against disabled people by treating a disabled person less favourably for a disability-related reason than a person who is not disabled. Less favourable treatment is defined as:

- Refusing a service
- Providing a worse standard of service or
- Offering a service on worse terms.

Since October 1999, service providers have had to take reasonable steps to:

- Change practices, policies or procedures which make it impossible or unreasonably difficult for disabled people to use a service.
- Provide auxiliary aids or services which would make it easier for, or enable, disabled people to use a service; and
- Overcome physical features (for example ones arising from design or construction of a building or the approach or access to premises) which make it impossible or unreasonably difficult for disabled people to use a service by providing the service by a reasonable alternative method.

The DfEE issued a Code of Practice entitled Rights of Access: Goods, Facilities, Services and Premises (DfEE, 1999b) specifying the duties of service providers which came into force in 1999. The Code gives examples of which service providers are covered, which include local councils, Government departments and agencies, the emergency services, charities, voluntary organisations, hotels, restaurants, pubs, post offices, banks, building societies, solicitors, accountants, telecommunications and broadcasting organisations, public utilities, national parks, sports stadia,
leisure centres, advice agencies, theatres, cinemas, hairdressers, shops, market stalls, petrol stations, telesales, businesses, places of worship, courts, hospitals and clinics.

Part III of the Act does not apply to services which are to do with means of transport (e.g. taxis, hire cars, buses, coaches, trains, aircraft and ships). However, transport providers are not wholly exempt from Part III, since they must avoid discrimination against disabled people and make reasonable adjustments in respect of timetables, booking facilities, waiting rooms etc at airports, bus, coach and railway stations. Part V of the Act allows the Government to set access standards for buses, coaches, trains, trams and taxis. Regulations have been produced for access standards for rail vehicles and similar regulations are planned for buses, coaches and taxis.

Services not available to the public, such as those provided by private clubs, are not covered by Part III of the DDA.

OFFICIAL STATISTICS

Figure 7.1 uses Scottish Household Survey data to compare the extent to which disabled and non-disabled people find access to services and premises convenient.

*Figure 7.1: Convenience of various services by disability status, Scotland 1999*
1 In the Scottish Household Survey, disabled people are identified by answering ‘Yes’ to the question: ‘Do you or anyone else in the household have any long-standing illness, health problem or disability that limits your/their daily activity or the kind or work you/they can do?’

Disabled people generally found services less convenient than non-disabled people. The service found most inconvenient by both disabled and non-disabled people was hospital outpatients department. The largest discrepancy between disabled and non-disabled people was also found in relation to this service.

REVIEW OF RESEARCH

Meager et al (1999) conducted research on the implementation of the first phase of the DDA (i.e. those measures which came into force in December 1996). The research covered the period December 1996 - mid-1998. During this period, throughout England, Wales and Scotland, only nine cases were brought to court in relation to goods, services, facilities and premises, a very small number compared with cases brought in relation to employment provisions. Most cases involved refusal of services to a disabled person by a service provider. Six of these cases had reached an outcome by mid-1998. One was successful at hearing, two were unsuccessful and three were settled or discontinued. In Scotland, one case has been brought and it was unsuccessful.

Case study evidence suggested that the main reason there were so few cases was that many potential cases related to provisions of the DDA that were not in force at the time of the research (i.e. those relating to policies, procedures and practices, the duties to remove/alter physical barriers and to provide auxiliary aids and services. Awareness of Part III provisions by disabled people and their advisers appeared to be low, and employment provisions of the DDA were seen as more important.

Key additional barriers to taking Part III cases included:

- The cost of taking a case and the heavy reliance on pro bono advice (legal aid is typically unavailable for these cases). The Scottish Legal Aid Board has refused to date to fund a Part III case on the grounds that the damages likely to be recovered are too low to justify the use of public funds.
- Lack of awareness among some legal advisers/representatives of the procedures for lodging cases and of wider disability issues. People with certain types of disabilities (e.g. people with learning disabilities) may
experience particular difficulties in securing appropriate advice and representation.

• The court system is seen by many people as daunting, intimidating and complex.
• A perceived lack of awareness among the judiciary of the DDA, and of disability issues in general.
• Lack of accessibility of parts of the court system for disabled people in terms of both physical arrangements, and the facilities available for disabled parties in cases.

ADVANCING THE RIGHTS OF DISABLED PEOPLE AND FUTURE POLICY INITIATIVES

The Government has announced its intention to adhere to the timetable for the implementation of the remaining part of the DDA. From 1st October 2004, service providers will have additional duties in relation to physical features that make it impossible or unreasonably difficult for disabled people to use their service. They may have to overcome the difficulty caused by the feature by taking reasonable steps to:

• Remove it
• Alter it
• Provide a reasonable means of avoiding it or
• Provide a reasonable alternative method of making the service available to disabled people.

The Government intends to introduce building regulations which will ensure that all new buildings are barrier-free.

As noted by Meager et al (1999), in order for the law to be effective, disabled people have to be able to use it. Sutherland et al (1999) identified a range of factors preventing disabled people from using available legislation including lack of support and legal advice, lack of well qualified solicitors and economic disadvantage which meant that seeking legal redress was not top of their priorities. To enable disabled people to use the law effectively, there is a need to address the underlying social and economic conditions which produce social marginalisation. The Disability Rights Commission is now able to bring cases, so it will be important to assess the extent to which this encourages more disabled people to bring cases.
Key research questions to be addressed include the following:

- What differences are evident in England, Wales and Scotland in relation to the type of cases brought under Part III of the DDA?

- What difficulties are reported by disabled people in bringing cases and what support do they feel is necessary?

- What level of awareness of Part III of the DDA exists in different parts of Scotland and GB amongst service providers, disabled people and the general public?

- What changes in provision of goods and services have been made by a range of service providers in public, private and voluntary sectors to comply with Part III of the DDA? What factors influence people’s willingness to make changes? How effective are public information campaigns?
8: CONCLUSION

INTRODUCTION

In this concluding chapter, we first return to the key elements in the overarching policy context to consider, on the basis of the evidence presented in earlier chapters, their likely effects on the achievement of greater rights for disabled people. Subsequently, we outline some future avenues for research and consider the nature of the statistical data which will be needed to allow progress in different policy areas to be monitored.

THE OVERARCHING POLICY CONTEXT: KEY THEMES

The impact of devolution
Under the Scotland Act, considerable powers are devolved to the Scottish Parliament. But key elements, principally taxation, employment and social security, are reserved to Westminster. Since almost 50% of disabled people of working age are unemployed compared with 20% of non-disabled people (ILO definition of unemployment - see Chapter 3), social security and employment policy are critical. It will be important to research the impact of the DDA in Scotland and compare the situation of disabled people here with other parts of GB to identify what is distinctive about the Scottish approach to equality and ensure that Scottish people are not disadvantaged compared with the rest of GB. By the same token, Scotland may have important lessons to teach England, Wales and Northern Ireland in implementing equality strategies.

The promotion of human rights
The original timetable for full implementation of DDA is being followed and the extension of disabled people’s rights will have a positive effect on their social position. However, to challenge discrimination individuals need to be able to assert their rights. Major limiting factors are likely to be poverty and social exclusion. Research by Meager et al (1999) demonstrates employers’ lack of awareness of existing employment measures. Only four cases have been won at employment tribunal in Scotland since the passage of the DDA and only one case has gone to court in Scotland under the goods and services provisions of the DDA. It is clear that granting rights, whilst necessary, is not sufficient to transform society. In future years, the power of the DRC to raise public awareness, provide advice and consultation, and assist disabled people to bring cases to court should have a major impact on the attainment of social justice.
The social inclusion agenda
Clear evidence has been presented in earlier chapters that disabled people are particularly likely to be poor. The mechanism here is two-fold. First, disability discrimination in the workplace is still prevalent and benefits rarely provide adequate living standard. Secondly, people who are poor are much more likely to experience impairing conditions as a result of disadvantage in their home and working lives. Statistics presented in Chapter 6 show that children in disadvantaged neighbourhoods are more likely to be killed or injured on roads. Whilst poverty tends to be concentrated in urban areas in the west of Scotland, rural poverty also poses particular problems for people in Scotland in terms of isolation and lack of services (Shuksmith, 2000).

The social inclusion agenda adopts key principles of the audit culture. Milestones are identified and performance indicators used to measure progress. Whilst there are clearly strengths in such an approach, there are also problems, since complex issues which are less susceptible to monitoring may be ignored. It is therefore extremely important for policy makers to recognise disabled people as a key social group whose position needs to be closely tracked.

‘Joined-up policy’ and inter-agency working
The need for a greater degree of inter-agency working is a major social welfare theme. Previous chapters demonstrate the forging of linkages between education, employment, health, benefits, housing and transport policies. A key feature of the modernised welfare state is the creation of person-centred, flexible services delivered for the benefit of the service user, not the service provider. Direct payments, for example, provide money for a disabled person to purchase support services needed from public, private or voluntary sector providers not just for personal care at home, but also in the workplace.

Joined-up policy, however, is not always easily achieved. In Scotland, the fact that health boards and local authorities do not map onto each other creates barriers to inter-agency working. In addition, policies may pull in different directions, creating perverse incentives and resistance to change. Examples are given in this report of tensions between housing, benefits, employment and health policies which encourage people towards dependence rather than independence. Whilst the difficulties are now acknowledged, they have not been ironed out.
EXTENDING AND MONITORING THE RIGHTS OF DISABLED PEOPLE IN DIFFERENT POLICY ARENAS

In the following sections, we summarise extension to the rights of disabled people in specific areas and the information which will be needed to chart progress.

Education

The SEN and Disability Act has the potential to make school and post-16 education far more inclusive, but much will depend on the willingness of EAs and schools to plan for change and on disabled children and adults to challenge discrimination. Implementation of the DDA thus far suggests that disabled people are hesitant to bring cases. In some areas, policies are pushing in the same direction, for example the Quality Assurance Agency’s Code of Practice seeks to ensure that policies and practices in higher education institutions the rights of disabled students, thus supporting the spirit of the DDA. In other areas, however, there are tensions. For example, in both higher education and schools the focus on raising standards means that professionals may invest their energies in this direction rather than in creating an inclusive environment, although of course the two activities are not necessarily mutually exclusive. Policy makers need to ensure that such unhelpful tensions are avoided and that inclusion is an ‘incentivised’ activity.

In schools, there is a danger that children with SEN and their parents in Scotland may have weaker rights because of the existing legislative framework. There are strong arguments for the formulation of a Code of Practice on assessment and recording in Scotland and for the establishment of a Tribunal system to deal with disability discrimination cases as well as appeals concerning school exclusions and placement requests.

In relation to pupils in school, the Scottish Executive plans to gather individual pupil data which will enable much more sophisticated analysis to take place. It will be important to consider carefully the criteria used to establish a pupil’s SEN/disability status to ensure that data are valid and comparable across authorities. There is also a need for a more rigorous definition of disability to be used in gathering post-16 statistics. Whilst information on higher education students is relatively easily available, information on further education students and those undertaking LEC training programmes is difficult to obtain. In order to monitor provision effectively, data are needed on all forms of post-16 education and training.
**Employment**

About half the disabled population of working age are unemployed and this is a key element in their social exclusion. The implementation of further DDA measures relating to employment in 2004 is very positive, with a wider group of people covered by the law. However, the success of the Act depends on employers acting to ensure compliance and individual disabled people bringing cases to establish precedents. Evidence from the earlier implementation phases suggests that employers have been complacent and unwilling to improve their practice until forced to do so. Ongoing monitoring of Part II of the DDA is needed with a comparative element to assess relative rates of progress in different parts of GB. This should include an assessment of disabled people’s assessment of the effectiveness of the legislation.

Employment Service programmes have traditionally been geared to disabled people with relatively low support needs, rather than people who require significant and ongoing support in the labour market. Current information to employers on ES programmes appeals to their goodwill as a means of expanding employment opportunities for disabled people. Given the emphasis on profit-making and efficiency in modern organisations, the willingness of employers to employ more disabled people remains to be seen and should be closely monitored.

Measures to support disabled people with higher support needs, such as supported employment programmes, are often provided by voluntary organisations on shoe-string funding. If the goals outlined in the Learning Disabilities Review (Scottish Executive, 2000d) are to be realised, then the funding of supported employment providers needs to be placed on a more secure footing.

As noted above, the employment-focused programmes of Local Enterprise Companies targeted at disabled people have not been closely and routinely monitored. There is a need to set clear service standards and to review regularly disabled people’s experiences of these programmes.

There are ongoing tensions between social security and employment programmes which need to be resolved. For example, a person with learning disabilities requiring housing benefit is still likely to be restricted to ‘therapeutic work’ with penalties for working more than 16 hours a week. There is a need for a far more flexible approach between employment and benefits, so that an individual may work for longer hours when they feel able
without jeopardising their benefits status. These problems are recognised by Government, but are not yet resolved.

There is a need to focus not just on employment, but also on benefits. Since 50% of disabled people are forced to depend on social security, poverty will remain a problem until levels of benefits ensure that disabled people ‘get the support they need to lead a fulfilling life with dignity’. (DSS, 1998 p.51)

As noted in Chapter 3, whilst the Labour Force Survey provides statistical information on the economic activity of disabled people in Scotland, allowing comparison with other parts of the UK, evaluations of the NDDP and Employment Service programmes have tended not to disaggregate Scottish data. Such information is needed to shed light on the specific conditions operating in Scotland (large rural areas and concentrations of urban poverty) and to illuminate the effectiveness of the social inclusion strategy in Scotland compared with other parts of the UK.

Health and social care

Broad brush health and social care policy envisages a blurring of these two services which have traditionally existed separately. Health and social care services in the future, it is hoped, will deliver a seamless web of services to ensure health and well-being of people in communities rather than treat illness and distress in institutional settings. Our review of these policies suggests that a unified system of this type has yet to be achieved. Health services continue to focus on impairment-specific populations and on treating illness. Statistics and research describe treatments and outcomes rather than service users’ experiences.

There are, however, a number of interesting developments which indicate the future direction of services. For example, there are moves away from residential care (although there are some contradictory trends, e.g. a growing number of people with learning disabilities being looked after in nursing homes). Joint commissioning and funding arrangements are being put in place for certain groups of people requiring a high degree of support. Community-based health services are seen as preferable for the vast majority of disabled people, although an ongoing role is envisaged for specialist services geared towards those with profound and multiple disabilities.

In terms of social care, the Scottish Executive is encouraging local authorities to develop direct payment schemes so that individuals purchase the services they need rather than receiving standardised services. Despite official endorsements, such schemes are in their infancy and tend not to
include people who are deemed incapable of managing their own care. There are also some dangers in these schemes. For example, personnel problems have to be dealt with by the individual disabled person and there is some uncertainty about the purposes for which payments may be used. For example, Employment Service personnel are not always aware that direct payments may be used to help an individual at work as well as at home.

Overall, there is a need to monitor the extent to which health and social care services shift their focus towards meeting individual needs in mainstream rather than specialist settings. In addition, as major employers it will be important to monitor the way in which the NHS in Scotland and local authorities comply with the requirements of the DDA relating to employment and goods and services.

In terms of available statistics, it is evident that ISD has an extensive database, but this is not readily accessible to many people. Information on which groups of people experience which impairing conditions is useful, but it is only part of the picture. Far more data are needed on disabled people’s experiences of and access to a range of health and social care services, including direct payments.

Housing
Within housing policy, there has often been a somewhat unhelpful division between special needs housing, which has been seen as a community care issue, and mainstream housing, which has been largely unmonitored. There are now moves for an inclusive approach to housing policy for disabled people, with attention paid to the accessibility of all housing stock whether in the private or social rented sector. Ownership options for all disabled people are being promoted and new building regulations will apply across the board. The new Housing (Scotland) Bill envisages a strategic role for local authorities as regulators rather than major service providers and Scottish Homes is to become an executive agency of the Scottish Executive more closely tied in with national policy objectives.

Disabled people with high support needs experience particular problems in accessing suitable housing. The closure of long-stay hospitals means that new types of accommodation in the community are required which will provide support in small group or individual settings. There is some evidence that some people have moved from long-stay hospitals into hostels or nursing homes which may offer few additional opportunities for independent living. Housing benefits rules often reinforce dependence and the
Government’s Supporting People programme is attempting to unravel some of these unhelpful policy knots.

The statistics presented in Chapter 5 indicate that Scotland’s homes are in a poor state when measured against accessibility standards and housing stock is used inefficiently, with almost half of adapted homes occupied by people who do not require such adaptations. In both social rented and private housing sectors, there is clearly a need for closer monitoring of housing stock, so that there is a better matching between people who need houses and available local provision. The impact of new regulations introduced under the DDA needs to be monitored. The model of data gathering established by the Disabled Persons Housing Service Lothian, based on the collation and analysis of Personal Housing Plans, might be extended across the country.

**Transport**
Throughout the 1980s and early 1990s, transport policy focused on private rather than public systems and market solutions took the place of a planned approach. The Government is committed to developing a planned and integrated housing system which meets the needs of minority groups, not just those with the greatest spending power.

The provisions of the DDA and the Transport (Scotland) Act are intended to lead to improvements in infrastructure and developments need to be monitored. The deadlines set by government for all public transport vehicles to be accessible to disabled people are far into the future and some modes of transport (ferries, aeroplanes) are not covered by the DDA. The effectiveness of the new partnership arrangements between public and private sectors in developing integrated transport systems remains to be seen. In particular, firmer legislative measures may be needed to get privatised bus and railways to prioritise accessible transport, backed up by appropriate staff training. Much better information is needed on the accessibility of public and private transport systems for different groups of disabled people.

**Access to Goods and Services**
The Government has announced its intention to adhere to the timetable for the implementation of the remaining part of the DDA. From 1st October 2004, service providers will have additional duties in relation to physical features that make it impossible or unreasonably difficult for disabled people to use their service. They may have to overcome the difficulty caused by the feature by taking reasonable steps to remove, alter, avoid or make
reasonable adjustment to it. As noted above, new building regulations will also be implemented in 2004. Monitoring the implementation of Part III of the DDA is required to capture differences across GB and within Scotland. This will involve charting the views of disabled people, service providers and the general public over time.

Across different policy areas, it is evident that research is needed which will:

- Assess the impact of DDA and human rights legislation in Scotland
- Compare the impact of the DDA in different parts of GB
- Explore the treatment of disability issues within the wider social inclusion agenda
- Investigate the experiences of disabled people as group, but also the specific experiences of groups such as people with mental health problems, people with learning disabilities, disabled children
- Explore associations between disability and other social variables such as social class, ‘race’, gender, locality

Future research will employ both qualitative and quantitative methods as appropriate and needs to be underpinned by a much more reliable statistical base. To achieve this, there is a need for the harmonisation of survey questions. There is also a need for the production of regularly updated statistical digests which summarise information on disability in specific policy areas, with signposts to data sources. A number of agencies, including the DRC, the Scottish Executive and the UK government will need to work together to achieve this. Voluntary sector organisations, such as the Joseph Rowntree Foundation, also have a key role to play here.

CONCLUSION

The Disability Discrimination Act, now backed up by the enforcement powers of the DRC, has the potential to make a significant difference to the lives of disabled people. The existence of the legislation and the Commission conveys a strong message that a just society requires the full participation of disabled people. However, barriers to overcoming discrimination remain; these include lack of support and legal advice and a dearth of well qualified solicitors. In addition, the social and economic disadvantages experienced by disabled people mean that the struggle for survival may take priority over the quest for legal redress. As noted earlier, knowledge is a powerful tool in the struggle for justice, and this report is an attempt to provide an over-view of the big picture. In the future, we hope that well-planned and conducted research, backed up by reliable and accessible statistics, will be used to monitor progress and identify areas for future development.
References


Scottish Office (1997b) *Designed to Care: Renewing the National Health Service in Scotland* Edinburgh: The Stationery Office.


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